Religion, minority status and reproductive behaviour among Muslims and Hindus in India and Bangladesh

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To Bapa and Bou

Preface

Capturing in few paragraphs the entire gamut of experiences I have gone through during my PhD tenure is a daunting task. However, I can sum my experiences as a roller coaster ride whose highs and lows were greatly helped along by the company of some incredible people, some of whom I have had the privilege to work with, while others have always been a part of my support system. I treasure my experiences – both positive and negative – because I have learnt something new from each one of them.

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lodgings. I have enjoyed the dinners and movie sessions with her and she was wonderful in helping me cope with homesickness. I can never forget my first Christmas with her family in Noordbroek. It was like having a family away from home. I thank Paul, Annelies, Kathrijn and Oma for their kindness and hospitality. Thank you Marieke for all that you have done for me and for being my Paranymph. I am extremely grateful to Sharbani for helping me settle in Groningen. She introduced me to the Indian stores and showed me around. Whenever I had any problem I could always go to Sharbani's room. My heartfelt gratitude goes to Ajay for translating the Kannada interview guidelines and his hospitality before I commenced my fieldwork. I consider Karen a friend as well as my colleague. I also thank her for also helping me move between lodgings and enlightening me with regard to preparations for my PhD defence. Among the past and current stock of PRC members, I have enjoyed good times with Elda, Ganesh, Fanny, Anu, Erka, Rizwan and Louisa. A big thank you to Stiny for her assistance with numerous MVV, visa, health insurance and so on. I thank Alida for her assistance with the paperwork of my PhD defence.

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Bangalore, 4 October 2010

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Chapter 1: Introduction

1.1 Introduction

Religion holds immense significance in determining reproductive[1] behaviour, because of which a certain extent of regularity is expected in the fertility[2] levels of people who belong to the same religion. This regularity in the fertility levels of a religious group is expected because co-religionists are believed to be guided by the same religious principles. The religious rules are said to affect fertility by influencing believers and regulating their attitude towards fertility and family planning. The religions which have pronounced explicit rules governing reproductive behaviour, such as restriction on the use of contraception and induced abortion, have often attracted the attention of demographers. For instance, Catholics have been the centre of demographic contestation in America and Europe (for America, refer to Whelpton et al. 1966; Westoff and Jones 1979; and for Europe, refer to Coward 1980; Compton et al. 1985; Lesthaeghe and Wilson 1986; McQuillan 1999). In recent times, Islam has also attracted the attention of social scientists for its association with fertility in Africa, Middle East, Europe and South Asia (for Africa refer to Johnson-Hanks 2006; for Middle East, refer to Chamie 1981; Obermeyer 1994; and for Europe, refer to Westoff and Frejka 2007; for South Asia, refer to Ramesh et al. 1996; Moulasha and Rao 1999; IIPS and ORC Macro 2000; Reddy 2003; Dharmalingam and Morgan 2004;

[1] The term reproductive is used to connote the behaviouristic dimension of reproduction.
[2] The term fertility is specifically used to connote levels and trends.

Mishra 2004; Bhat and Zavier 2005; Davis 1951; Nag 1962; Stoeckel 1969; cf. Chaudhury 1981).

There are various explanations for the reproductive behaviour of religious groups. These are popularly termed as hypotheses and can broadly be categorised into four groups:

- The **characteristic hypothesis** (Petersen 1961; Lopez and Sabagh 1978; Bean and Marcum 1978; Riccio 1979; Kollehon 1994; Morgan et al. 2002; Iyer 2002) argues that religious differentials in fertility and contraceptive use result from differences in demographic and socio-economic characteristics.
- The **particular theology hypothesis** (van Heek 1956; Thomas 1983; Heaton and Goodman 1985) argues that religious doctrines and ideologies influence contraceptive use and reproductive behaviour. Religious doctrines and ideologies about marriage, family size, sex roles and birth control provide a system of norms and attitudes influencing childbearing preferences and contraceptive choice.
- The **minority status hypothesis** (Goldscheider and Uhlenberg 1969; Sly 1970; Kennedy 1973; Robert and Lee 1974) states that marginality, insecurity, and lack of upward mobility associated with minority group status influence contraceptive use and fertility behaviour.
- Chamie's (1981) **interaction hypothesis** maintains that fertility differentials depend on the interaction between the socio-economic levels of the religious groups and the local orientations of these groups toward procreation and fertility control.

Further, McQuillan (2004: 49-50) suggests an integrated approach in order to understand the conditions under which religion is likely to influence reproductive behaviour. He has outlined three conditions. First, the religion should pronounce rules that influence reproductive behaviour. Second, the religion should be able to translate its teachings to its followers and ensure conformity. Third, there exists a strong sense

of attachment among the followers as members of a community. The hypotheses and the conditions outlined by social scientists in the past brings to the fore the different dimensions of the linkage between religion and reproductive behaviour. Specifically, in order to gain a fuller understanding of the linkage there is a need to focus not just on religious rules that influence reproductive behaviour but also factors such as minority status, socio-economic context, nature of relationship between religious groups and the local context.

1.2 Relevance of the study

Lately, fertility of Muslims has garnered academic and political attention. This attention on Muslim fertility emanates from the interpretation of Islamic principles which are believed to be averse to the use of fertility control, specifically by restricting the use of sterilisation and induced abortion (Shaikh 2003; Keefe 2006). This restriction is based on the belief that any sort of manipulation in matters of reproduction shows lack of trust in God. This principle of Islam has earned it the tag of pro-natalism. Moreover, the tag of pro-natalism has also received political connotation in societies where Muslims register higher fertility because some (Huntington 1996 and Eberstadt 2001; cf. Johnson-Hanks 2006) interpret it as a conspiracy meant to outnumber other religious communities.

This impression of Muslims as pro-natalists is contested by scholars who argue that it is not possible to assign Muslims a single coherent fertility pattern across countries (Jones 2003; Johnson-Hanks 2006). Jones (2003) illustrates the variation in Muslim fertility by differentiating distinct categories. First, countries such as Algeria, Bangladesh, Indonesia, Iran and Turkey exhibit a total fertility rate approaching replacement level. Second, fertility in countries such as Azerbaijan, Bahrain, Brunei, Egypt, Jordan, Kyrgyzstan, Morocco, Qatar, and Uzbekistan is below three children per woman. Third, countries such as Afghanistan, Niger and Somalia have registered the highest fertility. Only six out of 15 Muslim majority countries have fertility rates of more than six children (Johnson-Hanks 2006). However, in countries such as India and Thailand, Muslims who are the religious minority there exhibit higher fertility

than the religious majority community (Knodel et al. 1999; Dharmalingam and Morgan 2004). It is evident from these facts that there is substantial variation with regard to Muslim fertility.

In the South Asian context, Indian Muslims have registered higher fertility compared to their Hindu counterparts (Ramesh et al. 1996; Moulasha and Rao 1999; IIPS and ORC Macro 2000; Reddy 2003; Dharmalingam and Morgan 2004; Mishra 2004; Bhat and Zavier 2005; Kulkarni and Alagarajan 2005; Alagarajan and Kulkarni 2008). Studies in Bangladesh (Davis 1951; Nag 1962; Stoeckel 1969; cf. Chaudhury 1981) have also reiterated that Muslims have higher fertility than Hindus. Similar to the international context "Muslim fertility" is politicised in India (Basu 1997; 2004) where Muslims are believed to have the potential to outnumber the Hindu religious majority (Joshi et al. 2004).

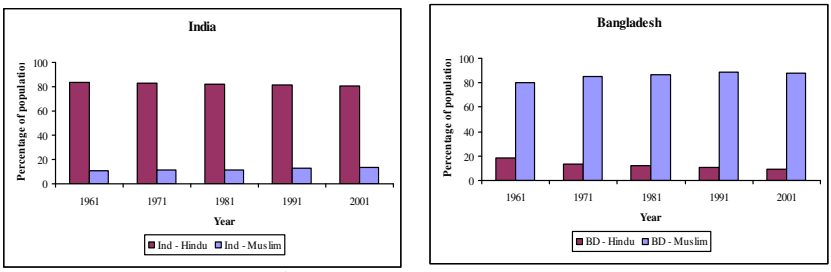
Religious majority or minority status is another route that could explain the fertility of religious groups in India and Bangladesh. For instance, Muslims are the largest religious minority in India (13.4 percent) and the religious majority in Bangladesh (87.8 percent). By comparison, Hindus are the religious majority in India (80.5 percent) and the largest religious minority in Bangladesh (9.3 percent). This unique Hindu-Muslim composition of India and Bangladesh provides a potent research setting to examine the role of religion as well as minority status in explaining fertility differentials of the two religious groups in India and Bangladesh. Further, since the two religious groups are differently positioned (as the majority/minority), it also enables the examination of the same group's fertility under varied circumstances (Kennedy 1973).

Prior to the examination of hypotheses through which the fertility of religious groups can be understood it is important to obtain an understanding of the demographic background of the religious groups under study. The following section elaborates the demographic background of Hindus and Muslims in India and Bangladesh.

1.3 Religious composition and fertility trends in India and Bangladesh

The year 1872 is distinguished as the year in which the first population census was conducted in the Indian subcontinent, which included Bangladesh as well. Since the inception of census-taking in Indian subcontinent, the population census has been collecting information on the size of each religious group. In the year 1974, the first independent population census of Bangladesh was conducted.

Figure 1.1: Percentage distribution of Hindus and Muslims in India and Bangladesh 1961-2001



Source: Kulkarni and Alagarajan, 2005[3]; Bangladesh Bureau of Statistics

Figure 1.1 indicates that since the last five decades, the percentage of Hindus (religious majority) in India shows signs of decline while the percentage of Muslims (religious minority) shows signs of increase.

This increase in the percentage of Muslim minority in India is interpreted by some as a possibility that Muslims will outnumber the Hindu majority. This scare has been highlighted in the popular discourse of India, which is termed as "Saffron Demography" by Jeffery and Jeffery (2005). Further, Basu (1997; 2004) argues that this label of high growth often attached to Muslims in India can be attributed to reasons beyond demography. However, the apprehension that Muslims will outnumber Hindus is unwarranted since it is not supported through empirical findings

[3] Computed from the population figures given in India, Register General of India (2004) and interpolated values for population by religion for Assam for 1981 and Jammu and Kashmir for 1991.

(Visaria 1974; Kulkarni 1996; Bhat 2004; cf. Bhagat and Praharaj 2005). However, empirical evidence suggests that the Hindu-Muslim fertility gap is narrowing with time (Bhagat and Praharaj 2005; James and Nair 2005). Given the sensitivity that surrounds the fertility levels of religious groups in the South-Asian context, the current research clarifies its position on the issue in the conclusion chapter (chapter 8).The rise in Muslim growth rate is often thought to be caused by the higher fertility levels of Muslims in India.

In Bangladesh, there is a gradual decline in the distribution of Hindus (religious minority) and a gradual increase in the distribution of Muslims (religious majority) over the last five decades (Figure 1.1).

The Bangladesh Bureau of Statistics (BBS) reports a slow trend of increase in the Hindu growth rate (BBS Internet access 2006). The reason for such a slow trend of increase is attributed to the lower fertility levels among Hindus (BBS Internet access 2006). However, growth rate is not a result of fertility alone. Migration plays a role in explaining the "slow trend of increase" observed among Hindus in Bangladesh. Apart from migration during partition in 1947, there has been a steady out-migration of Hindus from Bangladesh to India (Amin 1997; Dutta 2004). The difference in the growth rate of the two religious groups is often attributed to the different fertility levels of the religious groups. Thus, it is worthwhile to examine the fertility differential of Hindus and Muslims in India and Bangladesh.

According to estimates by Rajan (2005) based on data from the latest census (2001) of India, the total fertility rate (TFR) of Hindus in India is 3.1 and 4.1 for Muslims. According to the latest wave of the Demographic Health Survey (DHS) in India (National Family Health Survey 2006-2007), the TFR of Hindus is 2.59 and that of Muslims 3.40, for the 3 years preceding the survey (IIPS and Macro International 2007). However, the TFR of Hindus and Muslims is not published by the latest census or DHS of Bangladesh. It is not possible to estimate indirectly (using the reverse

survival technique) because the census of Bangladesh does not publish religion-related data for child-woman ratio, which is crucial for the estimation of TFR.

Table 1.1: The mean children ever born* and completed family size* for Hindu and Muslim women in India (1998-99; 2005-2006) and Bangladesh (1999-2000; 2006-2007).

		INDIA		BANGLADESH	
Indicators		**NFHS 2**	**NFHS 3**	**BDHS 2000**	**BDHS 2007**
Mean children ever born	**Hindu**	2.9	2.2	2.9	2.5
	Muslim	3.5	2.6	3.1	2.8
Completed family size	**Hindu**	4.4	3.9	4.9	4.2
	Muslim	5.8	5.3	5.9	4.7

* Calculations by the author

Figures in Table 1.1 suggest that in India the children ever born[4] (CEB) to Muslims is higher than for the Hindus. However, the Muslim-Hindu difference (3.5-2.9=0.6) in current fertility shows signs of recession (2.6-2.2=0.4) since the last two waves of the DHS in India. In Bangladesh, the current fertility of Muslims is higher than that of Hindus. However, the Muslim-Hindu difference in current fertility levels has remained the same during the last two waves of the DHS in Bangladesh. Table 1.1 further suggests that in India, the Muslim-Hindu difference in fertility (5.8-4.4=1.4) is more pronounced in the case of completed family size[5] (CFS) than current fertility. In India, there is a decline which is evident in the CFS for both Muslims (5.8-5.3=0.5) and Hindus (4.4-3.9=0.5). However, the Muslim-Hindu difference in lifetime fertility shows signs of stagnation (1.4) in the last two waves of the DHS.

In Bangladesh, the data from the latest round of DHS suggest that the Muslim-Hindu difference in lifetime fertility shows signs of convergence in that the difference has reduced from one child (5.9-4.9=1) to half (4.7-4.2=0.5). In summary, it can be

[4] CEB is an indicator of the current fertility of women (15-49) who are still active in their reproductive life course.
[5] CFS is the actual lifetime fertility of women (40-49) who have already completed their reproductive career.

concluded that current fertility difference between Hindus and Muslims is narrowing in India. However, there is no sign of recession in the case of actual lifetime fertility. Further, Muslim fertility is higher compared to that of the Hindus who have completed their reproductive career. In Bangladesh, the Muslim-Hindu difference in current fertility is low and the actual lifetime fertility shows signs of convergence.

Keeping this in mind, the present study seeks to ascertain whether the key to the explanation of the fertility differential between Hindus and Muslims lies in the religious principles, majority/minority status or the socio-economic context of the two religious groups in India and Bangladesh. Based on the relevance and background of the current research, the objectives and questions that the present research seeks to answer are discussed in the following section.

1.4 Research objectives and specific research questions

The present research seeks to answer the following research objectives and the specific research questions.

Research objective 1:

The present research seeks to explore the role of religion and minority status in reproductive behaviour.

Specific research question 1:

1.1 What is the effect of religious minority status on fertility at the cross-country level of India and Bangladesh and at the intra-country level of India?

Several studies, mostly in the American context, have tested the minority hypothesis during the 1960s and the early 1980s (18 articles and some chapters in book) (van Heek 1956; Day 1965; Goldscheider and Uhlenberg 1969; Sly 1970; Kennedy 1973; Roberts and Lee 1974; Ritchey 1975; Lopez and Sabagh 1978; Bean and Marcum 1978; Johnson 1979; Johnson and Nishida 1980; Rindfuss 1980; Gurak 1980; Cooney et al. 1981; Fisher and Marcum 1984; Swicegood et al. 1988; Goodkind 1995; Kohli

1998). However, there are very few studies in the 1990s. The reason for a decline in studies testing minority hypothesis in recent times is attributed by Goodkind (1995) to the methodological problems in operationalising the independent effect of minority status after controlling for socio-economic characteristics. Further, empirical testing of the minority hypothesis hardly exists for South Asia which requires studies that focus on the fertility of religious minorities in this region. Hence, the present research question seeks to fill that void. In addition, the present study addresses Goodkind's concern over operationalising the independent effect of minority status, by including adequate controls for socio-economic characteristics in the analysis. The present research question is answered in chapter 4 of the book. In addition to religious minority status, the present research also explores the role of religion in explaining the fertility of Hindus and Muslims in the comparative context of India and Bangladesh, and it is guided by two sub-questions as delineated in the following:

1.2 What is the effect of religion in explaining the fertility of Hindus and Muslims in India and Bangladesh?

If two religious groups in a given context exhibit different fertility levels, one of the reasons often attributed is the "religion effect". This "religion effect" in demographic studies is known as the *particularistic theology* hypothesis. The operationalisation of religion in demographic studies has assumed two forms, namely religious group affiliation (membership of a religious group) and religiosity. The existing studies that have examined the link between religion and fertility in South Asia have primarily used religious group affiliation as a proxy for religion (Dharmalingam and Morgan 2004; Bhat and Zavier 2005), except for Amin et al. (1997). Hence, there is a dearth of empirical study that examines the link between the individual level of religiousness and its impact on fertility in the South Asian context. Further, the implicit assumption of the existing studies is that mere membership of a religious community is the necessary precondition for influencing fertility. This assumption is marred because being born to a certain religious group does not automatically imply compliance to

that particular religious worldview. Further, it does not differentiate the extent to which one identifies with the religious views. In order to overcome this conceptual inadequacy, chapter 5 examines the role of religion, through individual religiosity and religious group affiliation, and it explores their linkage to fertility. In order to identify reasons behind the differential fertility of religious groups in India and Bangladesh the current research poses the following research question:

1.3 What can be learned from a comparison of Muslim reproductive behaviour in India with that of Bangladesh?

Unlike Hinduism, Islam prescribes specific dictums controlling reproductive behaviour. Hence, the current research question has confined itself to an in-depth examination of Muslim reproductive behaviour. Further, the comparative nature of the research presents an opportunity for the current research to understand the reproductive behaviour of the same religious group under varied circumstances. Linked to the previous question 1.2 which examines the fertility differentials of the two religious groups (Hindus and Muslims), the present research question 1.3 seeks to understand the reasons behind the observed fertility differentials by confining the study to Muslim reproductive behaviour. The in-depth exploration of Muslim reproductive behaviour in India and Bangladesh takes place in chapter 6 of this book.

Research objective 2:

The popular notion of Islam regarding reproductive behaviour is that it restricts human agency by limiting family planning practices. In order to test this notion, there arises a need to examine whether Muslims exercise agency in matters of reproduction on a day-day-day basis. Thus, the role of agency in reproductive behaviour of Muslims is explored in the Indian and Bangladeshi context through the following research objective:

The present research seeks to understand how agency plays a role in the religious domain of reproductive behaviour.

Another research question further probes into the role of human agency in reproductive behaviour:

> 2.1 How do women negotiate Islam in order to realise their reproductive aspiration in the cross-country context of India and Bangladesh?

The examination of only fertility differentials of religious groups often neglects the real reproductive issues that people face with regard to the religious principles. For instance, interpretation of Islamic religious principles and the manner in which people apply these principles to their reproductive behaviour. Further, Islam is said to restrict human agency through restrictions on contraception and induced abortion. Hence, the present study seeks to examine the truth behind the notions of Islam as a religion that restricts human agency. The value of the present study lies with the fact that the analysis of the issue is based on revelations by Muslim women themselves who tell their side of the story. The study of Muslim women in the comparative context of India and Bangladesh will yield insight regarding the role of agency for understanding reproductive behaviour that is far deeper than that obtained from a single-context study. The role of agency in negotiating reproductive aspiration finds place in chapter 7 of this book.

The present research dwells on the reproductive behaviour of Hindus and Muslims; however, more space is devoted to the latter in the book primarily because the fertility level of Muslims varies across the two countries, thus presenting an opportunity for the study to understand the process through which the same religion influences reproductive behaviour differently.

1.5 Theoretical background

Demographic theories that have tried to link religion and fertility through testing of hypotheses have neglected to consider social reality as a whole. This approach of fertility theories within the domain of demographic research is criticised by Greenhalgh (1995: 10) as “theoretically thin, substantively shrinking, and neglectful of global political and economic changes that are transforming its object of study”.

The present research tries to move beyond mere explanations of fertility levels based on speculations by exploring the underlying process through which religion and reproduction are linked. Addressing Greenhalgh's (1995) concern over the Eurocentric nature of fertility studies, the present research is grounded in the local context. Hence, the present study is not a blind application of theories that have their origin in the Western context.

Demographic studies linking fertility and religion in South Asia have treated religion as a part of a cultural "black box", without adequate exploration of the underlying process through which religion influences reproductive behaviour. The present study seeks to understand the underlying process through which religion and reproductive behaviour are interlinked. The present research adopts an approach similar to the one suggested by Greenhalgh (1995: 13) "that directs attention to the embeddedness of community institutions shaping fertility in structures and processes operating at regional, national, and global levels, and to the historical roots of the macro-micro linkages".

1.5.1 Overarching theoretical framework: Structuration Theory

The structuration theory is adopted by the present study in order to account for the macro-micro linkages in explaining reproductive behaviour of religious groups. The macro level or the structure connotes society, social systems, and institutions (De Bruijn 1999). The micro level or the agency connotes the individual actions, interactions, interpretation of situation and meaning attached to it (De Bruijn 1999). The dynamic relationship between different analytical levels has been elaborated through the structuration theory of Giddens (1984). In the structuration theory, Giddens (1984) contends that there is interdependent dualism between agency and structure (duality of structure). Further, Stone (2005) argues that Giddens's notion of duality of structure results from his conceptualisation of structure as both a *medium* in the practice of an agent and also as an *outcome* of these practices of the agent.

Structure is seen as the set of rules and resources which is consolidated as “memory traces” and system is the implication of the structure through the activities of human agents. Both structure and system are dynamic processes that survive through time and space. The activity of an agent in the day-to-day life situation is based on the knowledge of the situation. The role of the agent is given considerable credence by Giddens (1984) in the macro-micro interaction (duality of structure). The day-to-day activity of a social actor draws upon and reproduces structural features of wider social systems. The “typified schemes” of Schutz (1967) and the “interpretative schemes” of Giddens (1979) are what the actor resorts to in order to negotiate social life and influence social circumstances. Agency is seen as the intention of the actor to bring change in its life situation based on capability.

The normative component of interaction according to Giddens (1984) is seen as the “programmer of social conduct” which is sustained through normative sanctions. These norms inform the actor of the rights and obligations that are attached to the status that is held by the actor. This monitoring of social conduct can be understood through the concepts of signification, domination and legitimation. Signification is the symbolic order of coding, and domination is the condition for the existence of signification. Domination depends on the mobilisation of two kinds of resources namely allocative (transformative capacity and material phenomena) and authoritative or type of transformative capacity (command over actor). Legitimation refers to the normative regulation. Contextuality was stressed upon by the structuration theory through reflexivity between rules and practices. According to Garfinkel (1963) rules intersect with the practices in the contextuality of situated encounters. Agents incorporate temporal and spatial features of encounters in processes of meaning creation.

1.5.2 Proximate determinants of fertility.

The proximate determinant of fertility as developed by Bongaarts and Potter (1983) provides a comprehensive model to study fertility in the developing world. Bongaarts and Potter (1983) identify seven proximate determinants of fertility namely:

- marriage (and marital disruption)
- onset of permanent sterility
- post-partum infecundability
- natural fecundability or frequency of intercourse
- use and effectiveness of contraception
- spontaneous intrauterine mortality
- induced abortion

Bongaarts and Potter (1983) delineate the reproductive span of a woman's life into several stages of biological development. Menarche marks the biological onset of a woman's reproductive career. However, as marriage is the socially accepted norm of a stable conjugal union in the Asian context, it marks the onset of the actual reproductive career of a woman. A woman faces the possibility of bearing a child until the cessation of menstruation or onset of menopause or dissolution of marriage.

According to Bongaarts and Potter (1983), childbearing is inversely related to the duration of the birth interval. A shorter birth interval results in higher fertility and vice versa. In the absence of intrauterine mortality, the length of a birth interval is determined by:

- post-partum infecundable (non-fertile) interval
- waiting time to conception
- full term of pregnancy

Post-partum infecundability is the duration during which the woman does not resume ovulation as a result of breastfeeding and in some instances, sexual abstinence. The waiting time to conception is determined by frequency of intercourse, use or non-use of contraception and effectiveness of contraceptives. On an average a woman stays pregnant for the entire duration of gestation (9 months), which also reduces the risk of conception during that period.

Birth interval is longer and the pregnancy is shorter when the pregnancy ends in spontaneous or induced abortion. This is a brief infecundable period which delays conception (Bongaarts and Potter 1983).

1.6 Conceptual framework of the study

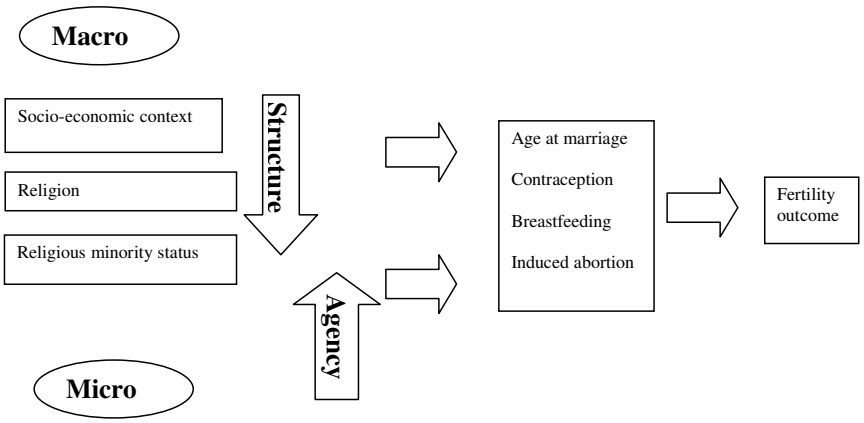
Figure 1.2 elaborates the overall conceptual framework of the present study which spans across the micro and macro order. In the present research, the linkage between the macro and the micro order is conceptualised through the religious rules, the religious minority status and socio-economic context. As discussed earlier, religious minority status and religion play an important role in determining a religious group's reproductive behaviour. The religious rules of Islam and Hinduism regarding reproductive behaviour are suggested as a possible route through which fertility levels of Hindus and Muslims can be explained. The impact of religious minority status on reproductive behaviour is two-fold: their disadvantaged socio-economic position as a result of discrimination and as well as the insecurity that arises from their marginalised status.

However, the current study drawing from the concept of duality of structure conceptualises the linkage between macro (religion and religious minority status) and individual reproductive behaviour as bi-directional. The role of the individual as a potential medium that can bring about change in the macro order is stressed upon in the current research. Structuration theory provides the necessary conceptual inputs to the present study to situate the role of structure (religion and religious minority status here) and agency (ability to bring change through the individual) in understanding reproductive behaviour. The link between the structure and agency is conceptualised as being dynamic.

The dynamism between the macro and micro order has implications for reproductive behaviour through demographic via-media. This demographic via-media has been conceptualised through the proximate determinants of fertility. The four most important proximate determinants of fertility in the current research are age at

marriage, contraception, breastfeeding and induced abortion. The macro influence (religious rules) has an important role to play in determining the differentials in the proximate determinants of fertility. For instance, the gender norms influence the age at marriage which in turn determines the reproductive span of a woman's life. Further, the religious rules regarding the use/non-use of contraception and induced abortion have implications for the birth interval as well as for fertility levels. Finally, the application of the religious rules to individual's reproductive behaviour depends on his/her perception of these issues and the extent to which he/she exercises agency.

Figure 1.2 Conceptual framework depicting the relationship between religion, minority status and agency for the reproductive behaviour of Muslims and Hindus in India and Bangladesh.



1.7 Methodology: Mixed methods in comparative research

In order to answer the first research question (1.1), the study uses secondary data. In order to answer the second (1.2), third (1.3) and fourth (2.1) research questions, primary data are employed. For the collection of primary data, the present study makes use of a mixed-method research design. A mixed-method research design entails the use of qualitative and quantitative methods. The use of quantitative methods in comparative research enables the assessment of probabilistic relationships between features of the social structure, which can be generalised whereas qualitative

methods help to identify variant patterns across fewer cases (Ragin 1989). The current research has employed both methods without pitting one against the other; instead they complement each other. Furthermore, in order to answer the research question which is situated in a comparative context, the methodology has been adapted to the comparative dimension (religion, rural-urban, country) in each phase of data collection. Detailed descriptions of the methodological issues at different phases are discussed in the methodology chapter of this book.

1.8 Methodology: Situating the researcher's positionality

The issue that is often ignored or omitted while discussing methodology is the role of researcher's positionality in the process of data collection. The researcher's personal identity and its representation in the field play a vital role in the collection of data through the use of qualitative method. Chapter 3 problematises the researcher's positionality through strategies of representation in the field. By sharing these experiences the research intends to inform other researchers regarding the relevance of discussing the researcher's positionality for data collection.

1.9 Outline of the book

The order of chapters in the current book starts with an introduction (chapter 1), followed by two chapters on methodology (chapters 2 and 3), four chapters which present the core results (chapters 4, 5, 6 and 7) and finishes with a conclusion chapter (chapter 8). The methodology chapters precede the core results chapters because it was considered appropriate to describe how the data were obtained before answering the research questions.

Chapter 2 describes the mixed methods that have been used in order to answer the research questions and elaborates the manner in which these methods have been incorporated in the current comparative research. The chapter first describes the source of secondary data. Second, the chapter gives a detailed description of the primary data collection starting with an extensive preparation. This is followed by a discussion regarding the nature of inter-linkages between the qualitative and

quantitative phases of data collection. Next, the actual execution of the three phases of the data collection (quantitative-qualitative-quantitative) is described. The processing and editing of the qualitative and quantitative data are also elaborated. Finally, the lessons learnt due to the comparative nature of the current research are reflected on.

Chapter 3 discusses the relevance of reflecting on the positionality of the researcher during data collection. The chapter situates the principal investigator's (PI) personal identity during the fieldwork across the varied religious, linguistic and nationalistic contexts and discusses its implications for the researched during face-to-face interviews. The chapter further elaborates the strategies of representation that have been used by the PI in the field. Finally, the chapter discusses the resonance of the researcher's positionality with the data.

Chapter 4 describes an empirical testing of the independent effect of religious minority status on fertility at cross-country and intra-country levels. The chapter starts with an introduction to the minority hypothesis and elaboration of conditions under which religious minority groups tend to exhibit high or low fertility. The chapter introduces the nature of operationalisations of minority status using secondary data sets - DHS (Demographic Health Survey) from India and Bangladesh and census of India. Conclusions are drawn and discussed in detail based on the findings of the research.

A comparative exploration of Hindu and Muslim fertility in India and Bangladesh is undertaken in chapter 5 in order to unravel the role of religion in explaining fertility, specifically birth interval. The chapter uses primary survey data to discuss the fertility differentials of the two religious groups in India and Bangladesh. Multivariate analysis is carried out to explore the role played by individual religiosity and religious group affiliation to explain the transition between parities. Further, an exploration of the differentials in the proximate determinants of fertility is carried out in order to identify the determinant that primarily explains observed fertility differential among religious groups in India and Bangladesh.

Chapter 6 undertakes an in-depth exploration of the reasons behind high fertility among Muslims in India compared to Bangladesh. A comparative examination of the context of both the countries is carried out to answer the question outlined earlier (1.3). Qualitative data are used to unravel the reasons for the high fertility trajectory of Indian Muslims. Finally, the chapter discusses a possible lesson that can be learnt from the Bangladeshi context and applied to the Indian context.

Chapter 7 outlines the induced theoretical framework that has emerged from the qualitative data using the analytical method of grounded theory. The induced theoretical framework describes the underlying process through which women negotiate their reproductive choice with the religious normative order. Giddens's structuration theory (1984) is used as a broader theoretical framework for situating the induced theory in perspective.

Chapter 8 is the concluding chapter that discusses the empirical results drawn from the analysis (chapters 4, 5, 6 and 7) in order to answer the main research questions raised in the current chapter of this book. The chapter also reflects on the methodological issues of the current research. Further, the chapter presents suggestions for future research and recommendations at policy and community level.

Chapter 2: Mixed methods in comparative research

2.1 Introduction

The present research seeks to explore the role of religion and religious minority status on reproductive behaviour in India and Bangladesh by adopting a comparative approach. The choice of the countries and religious groups for comparison is embedded in the theoretical and empirical background of the research topic. The religious composition of India and Bangladesh is unique - Hindus being the majority in India and the minority in Bangladesh, and Muslims being the minority in India and the majority in Bangladesh. Comparing the two religious groups that are differently positioned in a society (as the majority/minority) enables the examination of the same group under varied circumstances. Comparing the two religious groups positioned differently facilitates ascertaining whether it is religion or minority status that furnishes a stronger explanation (see Scheuch 1990) of fertility rates in South Asian context.

The present research makes use of primary and secondary data in order to answer the research questions outlined in chapter 1 of this book. The primary data were collected using both qualitative and quantitative methods in order to obtain information on various dimensions of reproductive behaviour. The use of quantitative methods in comparative research enables the assessment of probabilistic relationships between features of the social structure, which can be generalised (Ragin 1989). The qualitative methods help to identify variant patterns across fewer cases (Ragin 1989).

Furthermore, the comparative dimension (religion, rural-urban and country) of the current research required attention to details regarding the differences and similarities across research contexts. These similarities and differences across contexts were essential for contextualisation of the current research. For instance, in the present research contextualisation was required in three dimensions, namely country (India and Bangladesh), location (rural and urban) and the study group (Hindu and Muslim; men and women; majority and minority). Further, it was also important to standardise the research techniques and concepts across the research settings and groups in order to ensure a valid comparison (section 2.13.2). Application of a mixed-method research design in a comparative research is a less frequented methodological domain and the present research addresses important methodological issues of conducting such research.

2.2 Secondary data

To explore the role of religious minority status on fertility (research question 1), two types of secondary data sources were used. The following section will elaborate on these secondary data sources (Section 2.2.1). In order to ensure comparability of results, a close temporal proximity was maintained in the timeline of the three secondary data sets, namely DHS-India (1998-99), Bangladesh (1999-2000) and census of India (2001).

2.2.1 Demographic Health Survey (DHS)

The present research uses nationally representative data collected by the Demographic Health Surveys of India (National Family Health Survey 1998-99) and Bangladesh (Bangladesh Demographic Health Survey 1999-2000). The Demographic Health Survey of India (National Family Health Survey-2) is a collaboration between the International Institute for Population Studies, USAIDS, UNICEF, ORC Macro (USA) and the East-West Centre Hawaii (USA).

The Demographic Health Survey of Bangladesh (Bangladesh Demographic Health Survey 2000) is a collaborative effort of the National Institute of Population Research and Training, Mitra and Associates, and ORC Macro (USA).

The NFHS (1998-99) covered a nationally representative survey consisting of 89,199 ever married women aged 15-49 years across all the 26[6] states of India. For the rural and urban sampling domain of Indian DHS (1998-99), a systematic, multi-stage stratified sampling design was used. A two-stage sampling procedure was followed for the rural location and a three-stage sampling procedure was followed for the urban locations. The primary sampling unit (villages or group of villages) was first selected for rural location. To ensure representativeness, the NFHS has used the probability proportional to population size (PPS) principle for the selection of primary sampling units. In the second stage, the households were selected using systematic sampling. For urban location, the ward was first selected by applying PPS sampling procedure. This was followed by a selection of a census enumeration block (CEB) using PPS. In the third stage households were selected using systematic random sampling procedure from the selected CEB (IIPS and ORC Macro 2000).

The BDHS (1999-2000) covered a nationally representative survey consisting of 10,544 ever married women aged 15-49 years across all 6 divisions of Bangladesh. In the case of Bangladesh, a two-stage stratified sampling was employed. A master sample based on 1991 census which is maintained by the Bangladesh Bureau of Statistics was used to implement the survey. The primary sampling unit was selected from the master sample originally drawn through PPS. The units for the BDHS survey were sub-selected from the master sample with equal probability to make the BDHS selection equivalent to selection with the PPS sampling procedure (Niport et al. 2001).

2.2.2 Census

The present research also uses data from the census of India (2001) at district level. The latest census provides information on some of the important socio-economic

[6] At the time when NFHS (1998-99) was conducted, India consisted of 26 states.

determinants of fertility rates such as place of residence, education and workforce participation for religious groups at the state and district level. Although the census of India has been collecting information regarding the size of religious groups since its inception in 1872, details regarding socio-economic characteristics by religion were not made available until 2001 - which was the first time in the history of the Indian census that such information was accessible.

2.3 Primary data collection

For answering the second (1.2), third (1.3) and fourth (2.1) research questions, primary data were collected from four locations in India and Bangladesh. The present chapter elaborates the comparative methodological trajectory that was used. The following section concentrates on issues regarding primary data collection (Section 2.4-2.17). The details of data collection and definition of concepts are elaborated in the subsequent sections.

2.4 The sequence of data collection

This section elaborates the sequence in which the primary data were collected and the rationale behind such a sequence. The fieldwork was first commenced in India, followed by Bangladesh. The data collection was started in India first because the PI is an Indian and has a fair amount of knowledge regarding the socio-cultural background of the country. This enabled a feasible entry point in the initial phase. What also played a role in the beginning the fieldwork in India was that in Bangladesh the Research Review Committee (RRC) and the Ethical Review Committee (ERC) of the collaborating institute, the International Centre for Diarrhoeal Disease Research Centre (ICDDR, B), required research proposals to be approved before fieldwork could start in Bangladesh. This procedure takes quite some time. Hence, the data collection was first started in India. This also gave the PI some time to prepare all the necessary research documents required for the RRC and ERC in Bangladesh.

The data collection in each country started in the rural location, followed by data collection in the urban location. In India, data collection was first commenced in rural Dharwad because the Population Research Centre (PRC) at the University of Groningen, the Netherlands (host institute of the study), is engaged in collaborative research with the Population Research Centre (PRC) of the JSS Institute for Economic Research (IER) in Dharwad, India. Further, PRC at IER, Dharwad, was the first among the collaborators to provide the necessary support for the collection of data. This was followed by data collection in urban Bangalore, India, where valuable support was extended by the Institute for Social and Economic Change (ISEC), Bangalore. In Bangladesh, data collection was first commenced at rural Matlab because the collaborating institute for this study in Bangladesh - ICDDR, B - has a research base in rural Matlab. Further, ICDDR, B provided the necessary support for the collection of data from rural Matlab. This was followed by data collection in urban Dhaka where ICDDR, B extended support. ICDDR,B also involved their sister concern Asian Community Health and Preventive Research (ACPR) for the collection of baseline data from urban Dhaka.

2.5 Preparation for fieldwork

The preparatory phase before the actual data collection entails theoretical, conceptual, logistical and practical considerations. The different dimensions of the present research can be summarised in six basic questions:

How is research to be organised (support)? (Section 2.6)

Where is research to be conducted (location, country)? (Section 2.7)

Who is going to participate in research (participants)? (Section 2.8)

What is going to be asked (research instrument)? (Section 2.9)

Who is going to ask (research team)? (Section 2.10)

How is the comparative dimension of the current research taken into account? (Sections 2.6, 2.7, 2.10, 2.11, 2.13.1, 2.14.3, 2.15.1, 2.16, 2.17)

2.6 Collaborating institutes

Conducting data collection in a cross-country set-up is only feasible by collaborating with local research institutions (Oyen 1990). The Population Research Centre (PRC) of the JSS Institute for Economic Research (IER) in Dharwad and the Population Research Centre (PRC) at the Institute for Social and Economic Change (ISEC) in Bangalore are the collaborating institutes for the field research in India. The Health and Demographic Surveillance Unit (HDSU) of the International Centre for Diarrhoeal Disease Research Centre, Bangladesh (ICDDR, B), is the collaborating institute in Bangladesh. The collaborators extended not only necessary logistical support but also expert knowledge on the local settings and important insights pertinent for conducting field research.

The present research seeks to compare the reproductive behaviour of Hindus and Muslims. However, information on religious composition at the village and ward level is unavailable in both India and Bangladesh which is necessary considering the research objective of the study. In the absence of such formal information on religious composition, the experts in the collaborating institutes suggested the selection of research locations based on their past extensive research experience in the area. Experts at PRC, JSS institute (IER), also provided technical assistance in drawing a sample from the baseline data in the survey phase involving Dharwad. Further, the experts at the collaborating institutes gave their valuable feedback on the research instruments and also provided assistance in the recruitment of the research teams in the respective countries. Logistical support was extended by ISEC for conducting the fieldwork in urban Bangalore. Moreover, advice for the selection of urban wards was sought from census officials at the Directorate of Census Office in Bangalore. The selection of wards in urban Bangalore was based on expert advice of researchers stationed at ISEC.

The Demographic Surveillance Survey (DSS) which was collected by the HDSU unit at ICDDR, B was used as the baseline data to select the sample villages for the present study in rural Matlab. For urban Dhaka, the HDSU unit organised the

collection of baseline data through their sister concern ACPR. The HDSU unit extended other logistical support in rural Matlab and urban Dhaka. Discussions with researchers from these three institutions, regarding the local issues and practical information about the context, were very crucial for the PI in understanding the study set-up.

2.7 Selection of research locations

Selection of Karnataka as the research location in India was based on the religious composition of the state - 83 percent Hindu and 11 percent Muslims - which is in line with the Indian national average (80.5 percent Hindu and 13.4 percent Muslims). The data for the current research were collected from rural Dharwad and urban Bangalore in Karnataka, India. As mentioned earlier the selection of the rural and the urban research site was influenced by the research area of the collaborating institutes (section 2.6). Further, long-term collaboration with IER was considered important to facilitate the primary data collection in Karnataka. In Karnataka, rural Dharwad was chosen as the research site because IER has a research base in rural Dharwad. In Karnataka, urban Bangalore was selected as the research site because of the collaboration with ISEC, which has a research base in Bangalore. Further, Bangalore is the capital of Karnataka which is representative of an urban city of India. Data in Bangladesh were collected from rural Matlab and urban Dhaka. Long-term collaboration with ICDDR, B was considered important to facilitate primary data collection in rural Matlab and urban Bangalore because ICDDR, B has a research base in both the locations. The selection of villages and urban wards in the respective research sites is determined by the religious composition (sizeable proportion of Hindu and Muslim population) of these units.

2.7.1 India: Rural

The selection of the primary sampling unit, i.e. village in rural Dharwad, is based on the opinion of experts at IER, Dharwad, who had extensive knowledge about the Hindu and Muslim composition of villages in rural Dharwad. Shivalli and Kyarkoppa, two villages in rural Dharwad, were selected as data collection sites in India. The

village of Shivalli is situated in the northeast at a distance of 12 kilometres from the city of Dharwad. The village of Kyarkoppa is situated in the northwest at a distance of 5 kilometres from the city of Dharwad. The main occupation in both villages is primarily agricultural in nature. Table 2.1 presents the religious composition of the two villages, based on the complete coverage of the two villages which was carried out for the present research. The public infrastructure of Shivalli includes a bank, a veterinary hospital, a community hall, two *anganwadi* (kindergarten) and a higher primary school. The religious mapping of Shivalli shows that there are 10 Hindu temples and three mosques in the village.

In Kyarkoppa, there are two *anganwadi* and one primary school. There are six Hindu religious centres and two Muslim religious centres. Kyarkoppa lacks facilities such as a high school, bank, health facilities and community hall. The infrastructure in both villages suggests that the village of Shivalli has better socio-economic amenities compared to Kyarkoppa.

Table 2.1: Distribution of households and eligible women by religion, rural Dharwad *.

Villages	Total number of households enumerated	Total eligible women (%)		
		Hindu	Muslim	Total
Shivalli	599	85.3	14.7	100 (n=470)
Kyarkoppa	814	91.9	8.1	100 (n=686)
Total	1413	1032	125	1156

* Complete coverage conducted for the present research

Figure 2.1: Map of village Shivalli

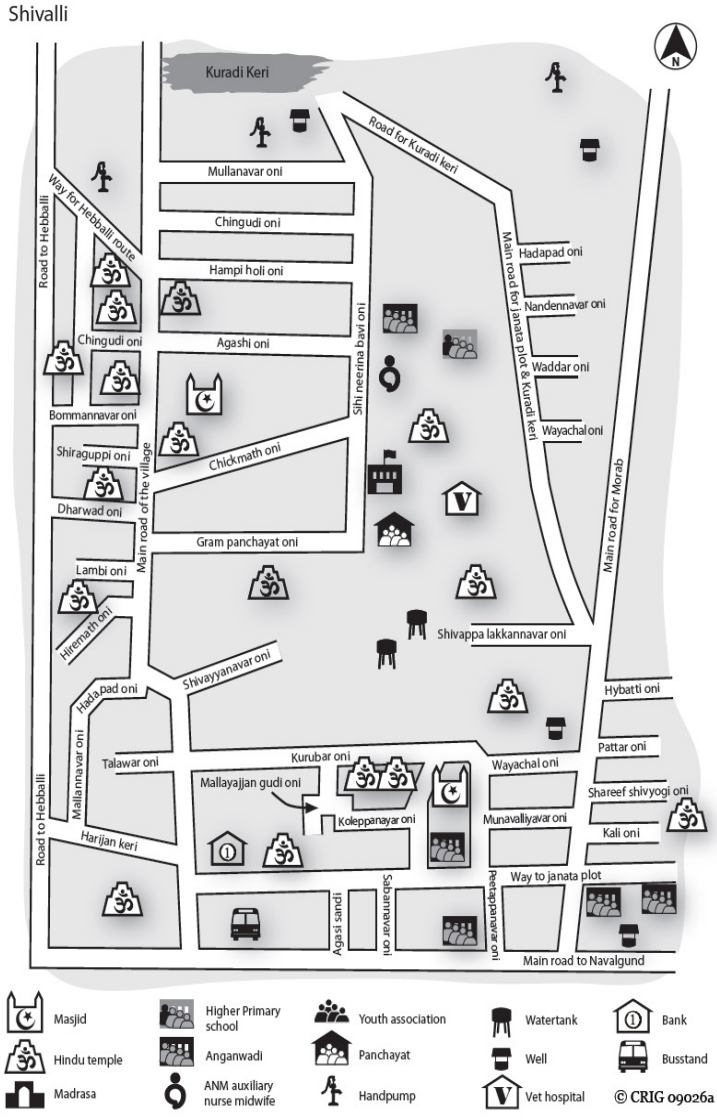
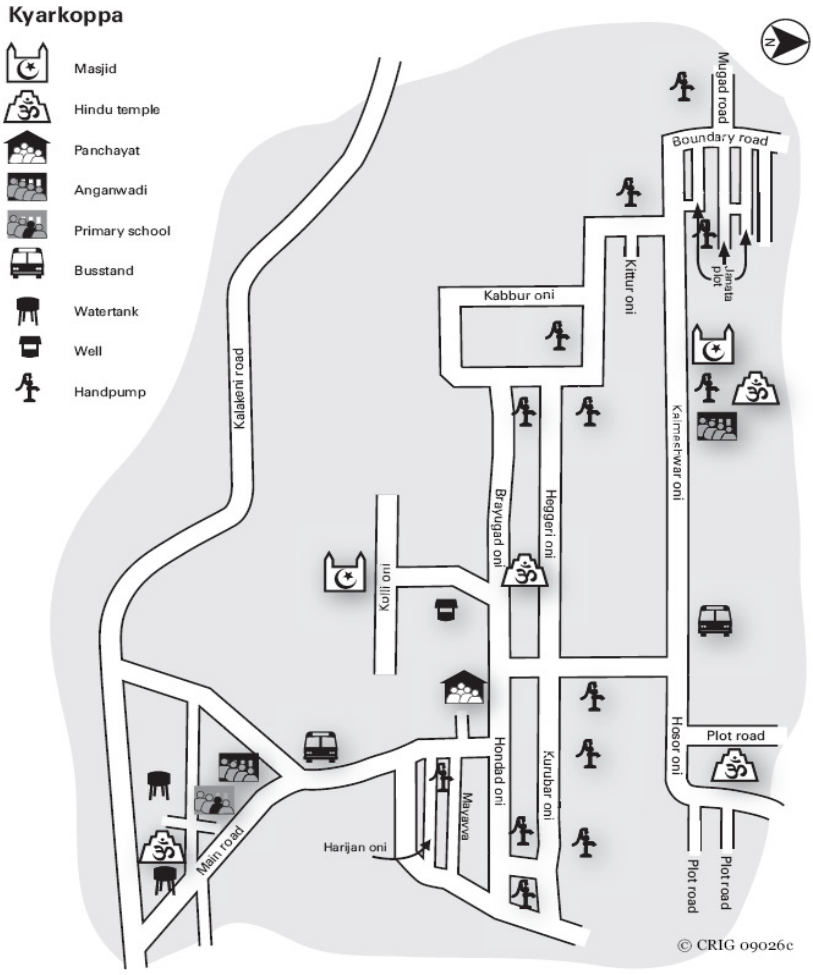


Figure 2.2: Map of village Kyarkoppa



2.7.2 India: Urban

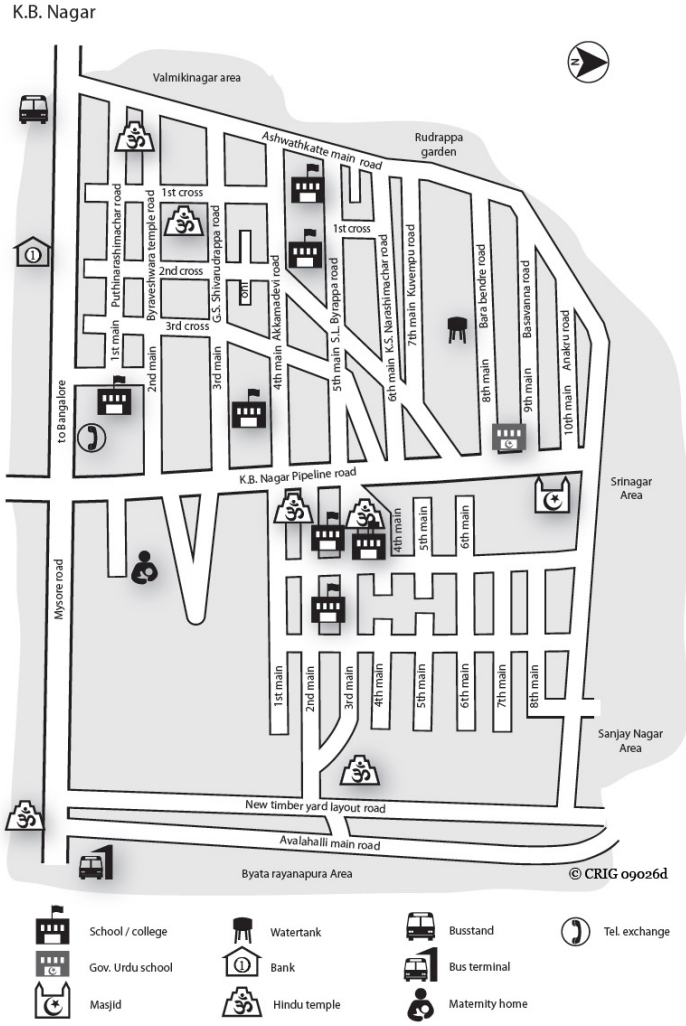
The selection of the primary sampling unit, i.e. ward in urban Bangalore, is based on the opinion of experts at ISEC, Bangalore, and census officials in Bangalore regarding the Hindu and Muslim composition at the ward level. In urban Bangalore, two wards were selected for data collection namely, Kasturba Nagar and Shammanna Garden. The two wards are situated adjacent to each other, with Shammanna Garden having a relatively higher concentration of Muslims compared to Kasturba Nagar. Both the wards are situated on the either side of the tollgate, on the Mysore Road area of Bangalore. One census block in each of the selected wards of urban Bangalore was randomly selected for the study. Table 2.2 presents the religious composition of the selected blocks from each of the wards based on the enumeration carried out for the present research.

Table 2.2: Distribution of households and eligible women by religion, urban Bangalore*

Urban wards	Total number of households enumerated	Total eligible women (%)		
		Hindu	Muslim	Total
Kasturba Nagar	847	95	5	100 (n=595)
Shammanna Garden	775	8.8	91.2	100 (n=716)
Total	1622	628	683	1311

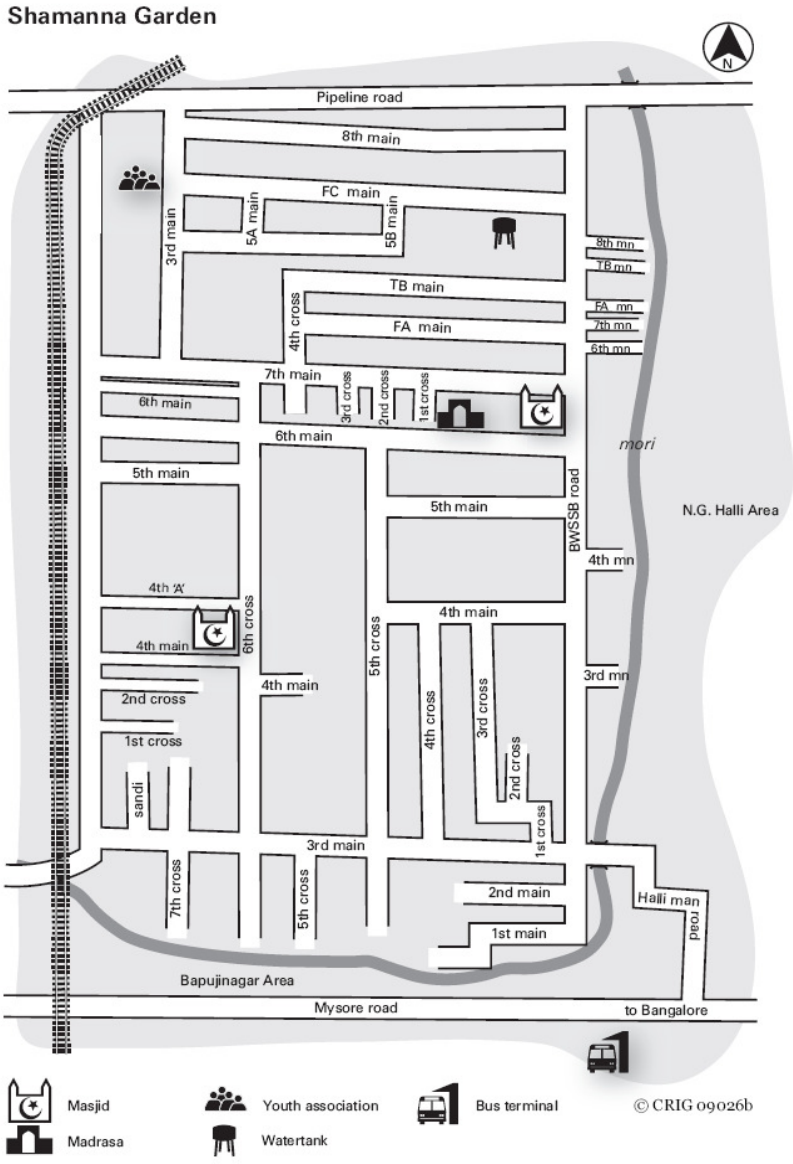
* Complete listing of the selected blocks was carried out for the present research

Figure 2.3: Map of ward Kasturba Nagar



There are six schools, one college, one hospital, one maternity home and a telephone exchange in Kasturba Nagar. There are also five Hindu temples and one mosque.

Figure 2.4: Map of ward Shamanna Garden



In the Shammanna Garden area there are two schools, two mosques and one *madrasa* (Muslim educational institution). Shamanna Garden lacks a higher educational institution, health facilities and telephone exchange and so on. The infrastructure in both urban wards suggests that in relative terms the Kasturba Nagar area (Hindu majority ward) is endowed with better socio-economic infrastructure compared to the Shammanna Garden area (Muslim majority ward).

2.7.3 Bangladesh: Rural

The research site of Matlab is located at a distance of 55 kilometres southeast of the country's capital, Dhaka. The ICDDR, B has been conducting field research in the Matlab region since 1963. The Demographic Surveillance System (DSS) was started in Matlab in 1966. Matlab was initially selected for testing the cholera vaccine. The DSS programme has been maintaining demographic and health-related records for 149 villages since 1978. The DSS area is further bifurcated into an intervention and comparison area. The intervention area comprises 70 villages which have participated in various family planning and health service intervention programmes. The comparison area consists of 79 villages which are devoid of any such intervention programmes (ICDDR, B 2007). Since the intervention area is not representative of the general population of Bangladesh, a conscious decision was taken in the present study to select villages only from the comparison area. Six villages namely Baishpur, Char Hori Gope, Sepoykandi, Durgapur, Namapada and Rayer Kandi were selected for data collection in rural Matlab, Bangladesh. These six villages were chosen based on the tabulation of the religious composition of the 79 villages from the comparison area because they had a substantial proportion of both religious communities, namely Hindus and Muslims. Rayer Kandi village has two mosque and two temples. Durgapur village has one high school, one primary school, one *madrasa*, four temples and three mosques. Sepoykandi village has one primary school, one mosque and one temple. Chor Horigope village has two temples. Baishpur village has four primary schools, nine mosques and three temples. Namapara village has one primary school, one madrasa and two mosques.

Table 2.3: Distribution of households and eligible women by religion, rural Matlab*

Village	Total number of households enumerated	Total eligible women (%)		
		Muslim	Hindu	Total
Namapara	228	74.2	25.8	100 (n=186)
Sepoykandi	319	89.8	10.2	100 (n=265)
Char Hori Gope	145	36.6	63.4	100 (n=131)
Baishpur	1738	83.3	16.7	100 (n=1543)
Durgapur	734	36.1	63.9	100 (n=629)
Rayer Kandi	609	74.4	25.6	100 (n=539)
Total	3773	2338	955	3293

*Based on mid-year population extracted from DSS data set, 2006

Rayer Kandi village is deprived of educational infrastructure. None of the villages have higher educational institutions. The villages of Baishpur, Chor Horigope and Sepoykandi are relatively closer to the health care facilities. The religious background of these six villages is presented in Table 2.3.

Figure 2.5: Map of Matlab study area, Bangladesh

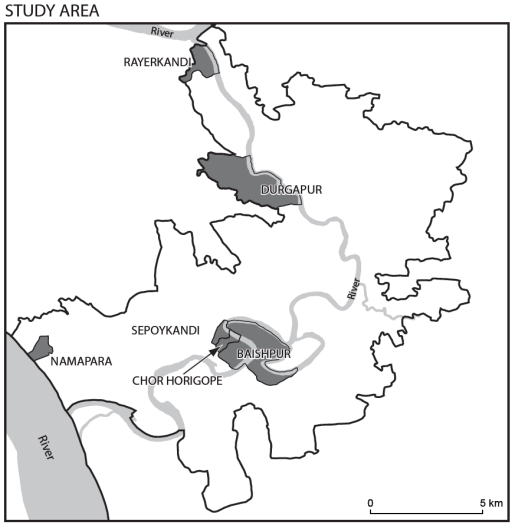


Figure 2.6: Map of village Rayerkandi

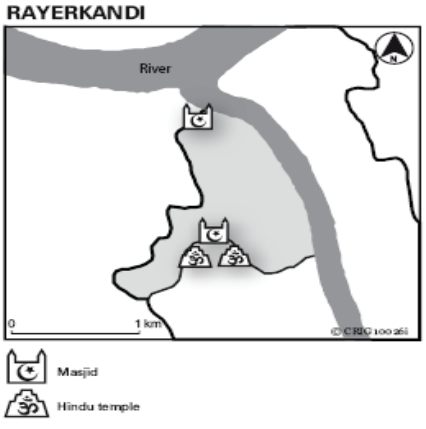


Figure 2.7: Map of village Durgapur

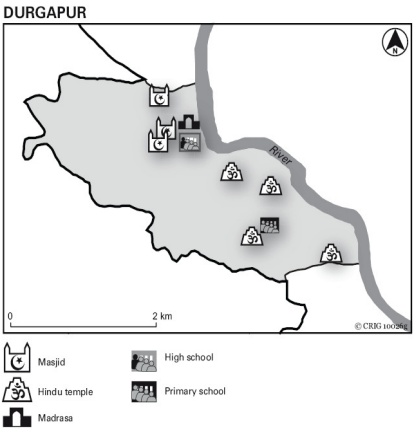


Figure 2.8: Map of villages Sepoykandi, Chor Horigope and Baishpur

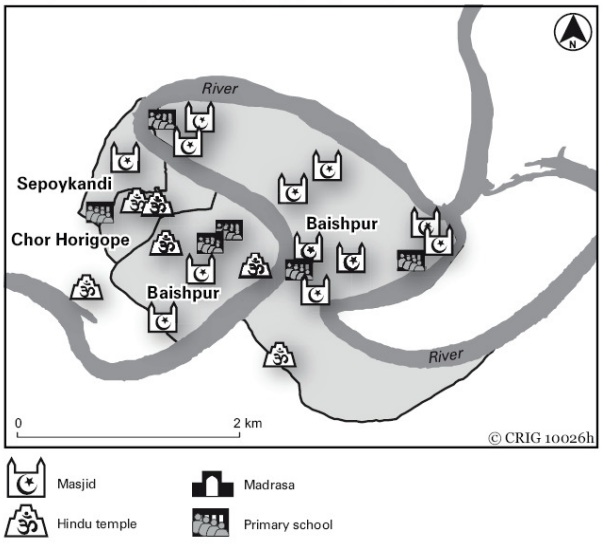
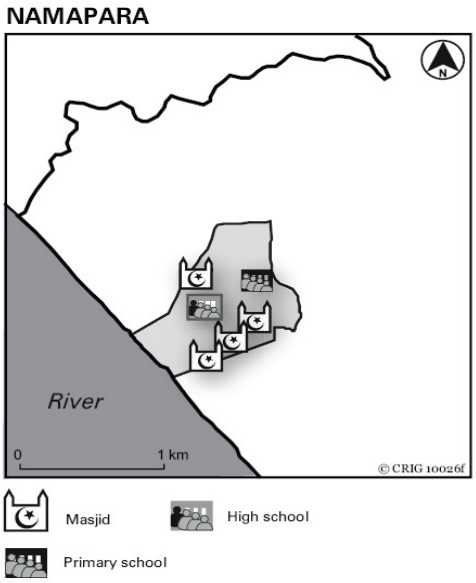


Figure 2.9: Map of village Namapara



2.7.4 Bangladesh: Urban

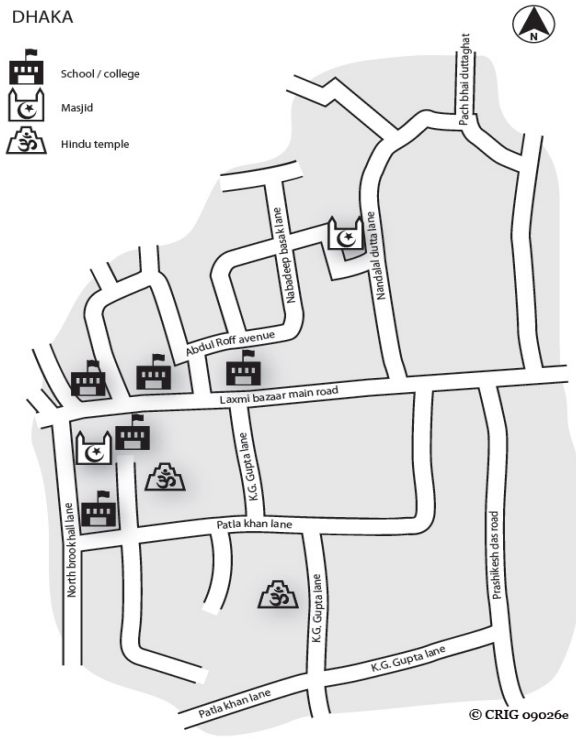
The selection of the primary sampling unit - i.e. ward in urban Dhaka - is based on the opinion of experts at HDSU, ICDDR, B and ACPR who were thoroughly familiar with the Hindu and Muslim composition at the ward level. The Lokkhi Bazaar ward was selected for data collection in urban Dhaka. There are five educational institutions including schools and colleges in the Lokkhi Bazaar area. There are two Hindu temples and two mosques in this location. Table 2.4 elaborates the enumerated households and religious composition of the census enumeration block in the Lokkhi Bazaar area.

Table 2.4 Distribution of households and eligible women by religion, urban Dhaka*

Urban wards	Total number of households enumerated	Total eligible women (%)		
		Hindu	Muslim	Total
Lokkhi Bazaar	1451	22.5	77.5	100 (n=1252)
Total	1451	282	970	1252

* Complete listing of the selected block was carried out for the present research

Figure 2.10: Map of ward Lokkhi Bazaar



2.8 Participants of the study

The data was collected through the use of in-depth interviews, key-informant interviews and survey methods. The participants of the in-depth interviews consisted of men and women from the Hindu and Muslim communities. Key-informant interviews were conducted with religious leaders and health personnel. The survey was conducted only among female participants from the Hindu and Muslim communities.

2.8.1 In-depth and key-informant interview participants

In order to explore the gender dimension of reproductive health, in-depth interviews were conducted among male and female participants. Key-informant interviews were also conducted among religious leaders, namely Hindu *purohit*[7] and Muslim *imam*[8], as well as among health personnel such as auxiliary nurse midwives (ANM) and community health research workers in the rural sites. Lady health visitors and doctors were interviewed in the urban research sites (details in section 2.9.2).

The focus of the present research is to understand reproductive behaviour. Hence, only women in their prime reproductive age group (18 to 44 years[9]) were interviewed. Child delivery and childcare practices constitute an important reproductive theme in the in-depth interview guidelines. Hence, only those women who have prior experience of childrearing were interviewed. Women from different educational backgrounds were interviewed since there is theoretical and empirical evidence suggesting an important role played by education in explaining reproductive behaviour. Hence, the criteria for the selection of female participants are:

1. religion: *Hindu and Muslim*
2. marital status: *currently married*

[7] Hindu priest
[8] Muslim religious leader
[9] The nationally representative surveys conducted by demographic health surveys consider the age bracket of 15-49 years as the reproductive age group for women. However, because the sample of this survey is small hence this study defines the female age bracket of 18-44 years as the prime reproductive age group.

3. age: *between 18 to 44 years of age*
4. maternity status: *Mother of at least one surviving child*
5. education: *Low, medium and high*

In the absence of a standard definition of the male reproductive age span, the present study arbitrarily set it in the 18 to 50[10] age groups. As discussed earlier, all other criteria for the selection of male participants are the same as for the female participants. Therefore, the criteria for the selection of male participants are:

1. religion: *Hindu and Muslim*
2. marital status: *currently married*
3. age: *between 18-50 years of age*
4. paternity status: *Father of at least one surviving child*
5. education: *Low, medium and high*

Since Hinduism is characterised by caste stratification, the present research attempted to recruit participants from diverse caste backgrounds. However, it was not feasible to maintain a strict caste group cut-off in the recruitment of participants, given the complexity and large number of caste groups among Hindus.

The religious leaders are said to play an important role in the reproductive lives of adherents. The present study has conducted key-informant interviews among religious leaders. Similarly, key-informant interviews were conducted among health personnel. The reason behind recruiting participants from varied backgrounds in the qualitative phase is not to generalise the findings, which is not the aim of qualitative research. Rather, the choice of varied backgrounds of the study participants is driven by theoretical considerations. Furthermore, the participants of the current research reflect the voices of those actors who are assumed to play an important role in explaining

[10] The nationally representative surveys conducted by demographic health surveys consider the age bracket of 15-54 years as the reproductive age group for men. However, because the sample of this survey is small hence this study defines the male age bracket of 18-50 years as the prime reproductive age group

reproductive behaviour. Table 2.5 elaborates the background of the 112 participants of the in-depth and key-informant interviews according to criteria set by the study: religion, country, location, gender and education.

Table 2.5: Distribution of qualitative research participants by country, residence, religion, gender, education and religious leaders.

	India		Bangladesh	
Currently married with one child	**Hindu**	**Muslim**	**Hindu**	**Muslim**
Women (18-44 years)	18	18	18	18
Men (18-50 years)	6	6	6	6
Religious leaders	4	4	4	4
Education (woman)				
Low	6	6	6	6
Medium	6	6	6	6
High	6	6	6	6
Education (man)				
Low	2	2	2	2
Medium	2	2	2	2
High	2	2	2	2
Place of residence				
Rural (woman)	9	9	9	9
Urban (woman)	9	9	9	9
Rural (man)	3	3	3	3
Urban (man)	3	3	3	3
Sum total		112		

2.8.2 Survey research participants

The present study recognises the crucial role that both men and women play in determining reproductive behaviour. Hence, the male perspective was sought in the qualitative phase along with the female perspective in order to understand reproductive behaviour. However, in the South Asian cultural context, childbearing revolves around women. Hence, the survey was conducted only among female participants. The religious composition of the women who participated in the survey is elaborated in Table 2.6.

The criteria for the selection of female participants for the survey are as follows:

1. religion: *Hindu and Muslim*
2. age: *between 18 to 44 years of age*
3. marital status: *currently married*

Table 2.6: Distribution of survey respondents by country, location and religion.

Currently married women in the 18-44 age group				
	India		Bangladesh	
Location	**Hindu**	**Muslim**	**Hindu**	**Muslim**
Rural	100	100	100	100
Urban	100	100	100	100
Total	200	200	200	200
Sum total		800		

2.9 Research instruments

The following section describes the research instruments that were used in the qualitative and quantitative phase: in-depth interview guidelines (Section 2.9.1), key informant guideline (Section 2.9.2) and questionnaire (Section 2.9.3).

2.9.1 In-depth interview guidelines

The themes in the in-depth interview guidelines derive from theories that inform the concepts of the present research (chapter 1). The structuration theory of Giddens (1984) informs the interconnection that exists between structure and agency. Demographic theories such as the proximate determinants of fertility (Bongaarts and Potter 1983) form a crucial part of the present study in exploring dimensions of reproductive behaviour. Demographic theories explaining fertility of religious groups (Goldscheider and Uhlenberg 1969; Kennedy 1973; Bean and Marcum 1978) have also contributed to the themes of the in-depth interview guidelines.

In-depth interviews were conducted with the aid of two sets of interview guidelines for male and female participants. The interview guideline for female participants

consists of 8 sections (Appendix B). The interview guideline for male participants consists of 7 sections (Appendix C).

The first four sections of the interview guidelines for female and male participants comprise of the proximate determinants of fertility, namely age at marriage, contraception, and breastfeeding and induced abortion. The other themes covered are cultural beliefs and practices revolving around pregnancy, delivery, postnatal care, nutrition, and childcare. The three most crucial themes of interview guidelines for male and female participants are religion, gender and minority status. The questions in the interview guidelines are arranged in the sequence of life course starting with puberty, marriage, childbearing, breastfeeding, contraception and abortion. The interview guideline for male participants is almost similar to their female counterparts. However, the questions are contextualised from the male perspective. An additional theme of the interview guideline for male participants is focussed on the male involvement in reproductive behaviour.

2.9.2 Key-informant interview guideline

Key-informant interviews were conducted among religious leaders and health personnel with the aid of two sets of interview guidelines. The interview guideline for the former consists of 7 sections. The themes in the interview guideline meant for religious leaders explore their interpretation of religious dictums in matters of reproduction. The opinions of religious leaders regarding the relation between the two religious communities and their perception of the study locality were explored through the in-depth interview guidelines (Appendix D). The in-depth interview guideline meant for health personnel consists of 9 sections (Appendix E).

2.9.3 Survey questionnaire

The survey questionnaire consists of 10 sections (Appendix G). The topics covered in the questionnaire include household particulars, individual particulars, puberty, marriage, contraception, fertility, gender dynamics, religiosity, minority status, anthropometric measurement and observations. The gender dimension of the research is operationalised in the questionnaire through the emic perspective. Female

participants of the research were asked to define their status in the family using their own parameter of what constitutes high status in the family. The different dimensions of religiosity included in the questionnaire are formal religiosity, religious activity scale, religious rites of passage and subjective religiosity. These dimensions of religiosity were developed based on the findings from the qualitative research. The scales of religiosity were developed based on findings from the qualitative research. Earlier study by Taylor and Chatters (1994) was helpful in the construction of the scales of formal religiosity activity and subjective religiosity. However, the blueprint for the questions was drawn from the qualitative research finding which was conducted prior to the survey (see section 2.13.1). The section on religious rites of passage and formal religiosity are primarily based on inputs from qualitative research.

The questions regarding the religious minority status are based on inputs from the qualitative research. There are 10 questions in the minority status section concerning cultural differences and similarities. These 10 questions were meant to assess the extent to which the participants perceive their community (group A) to be similar to or different from that of the other community (group B). Finally, the nature of relationship between the Hindu and Muslim communities is accessed through questions regarding nature of social interaction between the two communities, which is operationalised through participation of the two communities in each other's festivals and the quality of relationship between them.

2.10 Research teams

Since the present research is a cross-country research, two research teams were involved in data collection: one in India and one in Bangladesh. The same parameters were used to select the research teams in both countries.

2.10.1 Background of the research teams

The educational criterion used for the selection of the research teams for qualitative research was postgraduate level, specifically in sociology or anthropology. Based on the knowledge and practical experience of collecting qualitative data in the field of

reproductive health, the research teams were selected. Out of the three research assistants who were selected for the qualitative data collection in India, two were pursuing a PhD in anthropology and one was a postgraduate in sociology. In Bangladesh, out of the two research assistants who were selected for the qualitative data collection, one was a postgraduate in linguistics and the other a postgraduate in anthropology. All the selected research assistants had practical knowledge in collecting data using qualitative methods.

The research team which carried out qualitative research in India consisted of the PI (female) and three research assistants (two females and one male). The research team which carried out qualitative research in Bangladesh consisted of the PI and two research assistants (one female and one male). The PI along with the female research assistants conducted interviews among female participants and the male research assistant conducted the interviews among male participants. The gender composition in the research team was maintained in lieu of the strict gender norms prevalent in South Asia. These gender norms delineate the manner in which male and female social interactions should be conducted; for instance, women are not expected to speak to "strangers" (here, referring to research assistant) especially of the opposite sex. In the same light, the research focus, that is, issues of reproduction are primarily discussed between a man and a woman when they are bonded through marriage. The gender composition in the recruitment of the research team ensured a better rapport with the participants especially in administering culturally sensitive questions on issues such as contraception and sexuality. Female research assistants were helpful in that they played a crucial role in convincing the family members of the female respondents to participate in the research.

The Indian sub-continent is characterised by linguistic plurality. For instance, the two religious communities, i.e. Hindus and Muslims, speak different languages. The native language of Hindus in Karnataka is Kannada. The Muslims in Karnataka speak Dhakani, a colloquial dialect of Urdu - the language spoken by the majority of Muslims in India. Due to the religion-linguistic plurality characteristic of the Indian

set-up, the research team in India was composed of members who were conversant in both Kannada and Dhakani. The Hindu participants were interviewed in Kannada by the native Kannada-speaking research assistants. The PI conducted most of the Muslim interviews in Hindi a language that shares linguistic lineage with Urdu (Central Indo-European) and is understood by Muslims in India. The interviews in Kannada and Hindi were transcribed and translated by two professionals one a professor of linguistics and the other a postgraduate in English.

In Bangladesh, both Hindu and Muslim communities speak Bangla. The Bangladeshi research team was constituted of members who were native speakers of Bangla. The Bangla interviews were transcribed and translated by an English literature postgraduate.

Since the quantitative survey was conducted only among female participants, the survey research teams was solely composed of female research assistants. The requirement for the post of research assistant was at least a Bachelor's degree in social science along with experience in the collection of survey data. In India, the survey team consisted of three research assistants. In Bangladesh, the survey team comprised four research assistants. Both in India and Bangladesh, one of the research assistants who was part of the research team for collecting qualitative data was retained for the collection of survey data.

2.11 Training of research teams

The task of maintaining consistency across research teams became crucial due to the comparative nature of this study in two different countries. The PI was responsible for training the research teams and making them understand the aim of the study. The PI of the present study played a key role in maintaining consistency across the two research teams in India as well as Bangladesh. The PI trained both research teams following a standardised protocol which ensured that the training imparted to both the teams was similar. The PI trained the Indian research team in Hindi and the Bangladeshi research team in Bangla. The ability of the PI to communicate effectively

with both the research teams gave an additional leverage for training and monitoring the research process in all research sites. Further, a single research team collected data from both rural and urban locations from each country. This was done in order to ensure consistency in data collection within each country.

2.11.1 Training of qualitative research teams

The PI is not a native speaker of the languages spoken in the study locations in India (Kannada and Dhakani) and Bangladesh (Bangla). The research team members in most cases were not sufficiently competent in English. Thus, some strategies were developed to undertake the training of each research team. The English interview guidelines were translated and taped in Kannada by a colleague of the PI who is a native speaker of Kannada. The taped interview guidelines were given to the research team in India. The research team incorporated the local terms based on the taped questions. The PI trained the research assistants in Hindi (the national language of India). The research assistants were asked to translate each question from Kannada into Hindi so that the PI could ensure that the meaning of the translated questions remained close to the original version. This was also done in order to acquaint the research team with the questions and their meaning. After translation, mock interview sessions were staged where the research assistants interviewed the PI. These mock interviews were again conducted in Hindi so that the PI could make sure that the research team understood the actual meaning of the questions. The mock interviews were also conducted in order to ensure that the research team maintained the tone and temper appropriate to the meaning of each question. The research assistants were trained not to pose questions in an assertive manner but rather in a relaxed but firm manner. In the course of training, the research, team was asked to introduce sensitive questions or emotionally painful topics such as abortion, stillbirth and death of a child by saying “it sometimes happens that some pregnancies do not end up in a live child do you have such an experience?” The idea was to avoid causing the participant any emotional stress due to the nature of the interview question being posed. The interview guidelines were pre-tested first in the research site in order to prepare the research team and also to improvise the questions. The research assistant who was not

conducting the interview was asked to take detailed notes of the interviews in addition to the voice recording. This was done in order to have a back-up of the data in case of a technical snag during recording.

The research team in Bangladesh was also asked to translate the English interview guidelines into Bangla and contextualise the research instrument befitting the Bangladesh context. Since the PI can understand and speak Bangla, she could directly assess the appropriateness of the Bangla translation. In Bangladesh a similar training procedure was followed as in the case of India.

2.11.2 Training of quantitative survey research teams

The training for the survey phase was conducted over a period of seven days. The training started with the PI's presentation on the objectives of the research for all the eligible applicants. After the presentation the trainees were given a detailed account of what was expected of them during the research training and responsibilities to be undertaken by the selected trainees as part of the research team. In India, the Kannada version of the survey instrument was then introduced to the trainees and each question was discussed in a detailed manner. The meaning of each question was clarified and the trainees were encouraged to air their doubts or give their suggestion about the research instruments. The PI explained the manner in which each question was to be posed depending on the nature and meaning of the specific question. Three most competent trainees were selected out of the seven who participated in the training conducted in India based on several rounds of assessment. The assessment was based on interviewing skills and attitude of the trainees. In Bangladesh, four trainees out of the eight who participated in the training were selected.

The selected research team members were briefed about their dressing, mannerisms and behaviour that were expected of them during the data collection. *Salwar kammez* (Indian/Bangladeshi dress worn by unmarried girls) was worn by the PI and female research assistants during the fieldwork. This was done to ensure that research team

fitted into the cultural milieu of the research setting. Utmost care was taken by the research team to adapt to the location in which the fieldwork was conducted.

2.12 Ethical issues and committees

In order to ensure that the participant's convenience and time were valued, an appointment was made prior to each interview. The interview was discontinued and the same participant was visited at a later point of time in case the participant had to attend to some immediate work to attend to. In the cultural context of South Asia, especially in the rural context, when people are approached for an interview they often feel obliged to participate. In order to avoid any such situation, the research team refrained from goading any prospective respondent to participate in an interview. This was done with the aim of showing respect for the time and willingness of the participant and also to avoid getting data from someone who is not fully ready to participate. Additionally, the name of the participant was not recorded during the interview and also while analysing data in order to ensure anonymity of the participant. Before starting the interview the participants were informed of their right to decline or drop out of the interview at any point if they so desired. While obtaining the consent of the respondent to participate in the research, they were informed that the data collected were to be used solely for research purpose and will be accessed only by the PI. The participants were also informed that a voice recorder will be used during the in-depth interview and their permission was obtained before commencing the interview. In India, a verbal consent was solicited from the participants before starting in-depth and the survey interviews. In Bangladesh, a written consent[11] was taken before the interview.

In Bangladesh, the research proposal was approved by the Research Review Committee (RRC) and Ethical Review Committee (ERC) of the collaborating institute ICDDR, B. All the comments and suggestions given by both the committees were incorporated before the data collection commenced. The ERC had raised objections to

[11] As part of the guidelines set by the Ethical Review Committee of the collaborating institute in Bangladesh, ICDDR, B, written consent (Appendix A) was obtained before commencing interview.

certain questions in the section on minority status of the questionnaire. Following the suggestion of the ERC, the minority status section was dropped from the questionnaire and thus not administered in Bangladesh.

2.13 Inter-linkage between the three phases of mixed-methods

The present research adopts a research design which combines both qualitative and quantitative methods of data collection. The purpose of mixing methods is primarily to ensure complementarity. The research questions elaborated in chapter 1 of this book necessitated the use of two kinds of methods, where each method complements the other. This complementarity of a mixed-method research design is elaborated by Greene (2007) as "results from different methods serves to elaborate, enhance, deepen, and broaden the overall interpretations and inferences from the study". The current study demonstrates this complementarity between the qualitative and quantitative methods. For instance, the complete coverage (first phase) furnished baseline information for the qualitative data collection (second phase) and survey (third phase) data collection. The participants for the qualitative phase (second phase) were selected based on complete coverage data (first phase). The sample for the survey phase (third phase) was drawn from the baseline data collected through complete coverage (first phase).

Mixed-method research design is also used for the purpose of development (Greene 2007). The results of one method are used to inform the development of other methods. Qualitative data (second phase) was used to contextualise the survey instrument (third phase). The inter-linkage between the qualitative and quantitative phases is not limited to sharing data collected in one phase and transferring to the subsequent phase but also the sharing of methodological strengths from one phase in another. For instance, training the survey research teams in techniques of interviewing that are used in qualitative research. The following section illustrates the same approach.

2.13.1 Contextualisation of the questionnaire in comparative research

The in-depth interview guidelines and questionnaire, as already described, were contextualised for the two countries. This means that the guidelines and questionnaire remained the same in each country and rural or urban setting, but that locally relevant concepts – as gathered during an explorative phase of the qualitative research - were incorporated, thus making it easier for the participants to relate to.

For instance, the first tonsure – an important religious rite of passage in South Asia - is referred as *mundan* by Hindus whereas it is known as *hakika* among Muslims. A religious sermon among Muslims is known as *istama* while among Hindus it is known as *pravachan*. In India, the practice of religious offering on the occasion of fulfilment of certain wishes is known as *harke* among Hindus. Among Muslims it is known as *mannat*. Ritual fasting has a varied temporal dimension for the two religious groups: ritual fasting among Muslims is mostly limited to one month-long fasting - *Ramadan.* However, Hindus fast on different occasions spread throughout the year. In order to account for this difference between two religious groups, a new response category was included: one month in a year was included. The frequency of religious prayer was initially operationalised in the questionnaire through a 6-point scale: once a day, twice a day, once a week, few times a week, few times a month, to a few times in a year. However, it is customary for Muslims to offer *namaz* (prayer) five times a day. Thus, an additional option covering many times a day was included.

Since the fieldwork commenced in India first, the questionnaire was later modified for the Bangladeshi context. It was observed that some of the questions which were relevant to the Indian context were not applicable to the Bangladeshi context. For instance, the Muslims in India visit *dargah* (the grave of a *pir* - spiritual leaders) which is one of the prominent religious centre for Muslims. However, the practice of visiting *mazar* (another term for *dargah* used in Bangladesh) is rather rare and is believed to be un-Islamic in Bangladesh. Marital consanguinity is prevalent among both Hindus and Muslims in Karnataka, India, whereas marrying blood relatives is

considered a taboo among Hindus in Bangladesh. Thus, the questionnaire was accordingly modified.

The socio-economic situation of each country especially the rural context was adapted in the questionnaire. For instance, in Bangladesh a boat is an indicator of economic asset; however, in India an animal-drawn cart is an appropriate and comparable indicator of economic asset.

The terms used for contraceptive methods differ across both countries. For instance, sterilisation is referred to as "operation" in India and is known as "ligation" in Bangladesh. Further, in Bangladesh, there is a greater variety of contraceptives available as compared to the Indian context, for instance, injectibles and Norplant. These differences were taken into account while contextualising the questionnaire for the survey.

2.13.2 Retaining personnel from qualitative to quantitative

One of the research assistants who was part of the qualitative phase was retained in the quantitative phase in the research teams of India and Bangladesh. This was done in order to transfer the sensibilities of the qualitative phase to the quantitative phase. The research assistant who was part of the qualitative phase was promoted to the post of a research officer and she played a crucial role in the selection and training of the survey research team. Since the research officer had extensive knowledge of the research topic and was also oriented in qualitative methods, this enabled her to carry the knowledge and expertise into the second phase - survey phase. This carrying over of the qualitative methodological expertise into the survey phase turned out to be beneficial and enriching for the quantitative survey phase.

2.13.3 Application of qualitative method techniques in training survey research team

The present research employs techniques mostly used in qualitative methods in order to train the survey research team. For instance, certain sensitive questions need prior introduction before the actual question could be posed. For instance, polygyny (one

husband and many wives) in South Asia is considered to be a shame for the wife because "she is unable to keep her husband". In such a situation the question on polygyny was introduced as "Please do not be offended since I need to ask some personal information regarding your marriage. It sometimes happens that people marry more than once, do you have a similar experience". An adequate introduction to such sensitive questions plays a crucial role in building rapport with the respondent even while collecting data through the use of the survey method. This rapport plays an important role in obtaining better quality data. Further, conducting qualitative research before the survey ensures better understanding of the study setting before the survey commences. Such understanding can also play a crucial role in training the survey research team in a contextually appropriate manner. For instance, our qualitative data collection alerted us to the nature of peculiar responses that we might receive for some specific questions. Thus, the research team could be trained to handle such situations more effectively.

Techniques for training the survey research team were almost similar to the qualitative phase. The trainees were asked to interview the PI who sometimes posed as a difficult respondent in order to test the expertise of the trainee in handling such respondents. Furthermore, the trainees were asked to adopt a reflective technique of interviewing for posing certain questions. For example, in order to obtain an answer for abstract questions such as commitment to religious beliefs the trainees were instructed to make a reference to earlier questions asked on religious activity (such as praying, visiting temple, ritual fasting, etc.).

2.14 Execution of mixed-methods in three phases

Teddlie and Tashakkori (2006) argue that integration across phases of research is crucial for mixing methods. As mentioned earlier (section 2.13) the sequence in which the qualitative and quantitative data were collected was thoroughly integrated. First in the sequence of data collection, a complete coverage was conducted in order to obtain baseline data. In the second phase, explorative qualitative data were collected in order to understand the different dimensions of the research problem. Finally, the survey

phase was meant to quantify some of the concepts such as religiosity that was developed in the qualitative phase.

2.14.1 First Phase: Complete coverage

In the absence of data on religious composition at village and ward level in India and Bangladesh, the present research collected the baseline data through complete coverage. Baseline data was collected from three locations namely rural Dharwad (two villages), urban Bangalore (two blocks from two wards) and urban Dhaka (one block from one ward). Information on limited demographic and social characteristics was collected during complete coverage. The information collected in complete coverage were the number of members that reside in the household, the name of the head of the household, total number of eligible couples, age, religion, caste and sub-caste. The household list which was used for complete coverage is attached to the appendix (Appendix F).

Definition of concepts and data collection during complete coverage

The present study defined a household as a group of people who eat food cooked in the same hearth. The types of household in the study population can be categorised into nuclear, joint, co-residing or single. The head of the household provided the information on their behalf in case any one of the members was absent. The name of the head of the household and the husband of the woman were noted[12] which was used to identify the sample. The age of a woman as noted in the school certificate was the most reliable source of a woman's age. However, for an illiterate woman, age was estimated by summing up the age of the woman at major life events such as puberty, marriage and the current age of the latest child. While estimating age in the rural context, it was observed that the major life events are orchestrated around religious festivals or celestial events such as full moon and new moon. These cultural and religious festivals provided the most approximate reference point for the calculation of age. The religious festivals celebrated by Hindus and Muslims are different. Thus,

[12] South Asia is characterised by patriarchy in which a married woman is often identified as a wife or a daughter-in-law of a household.

for calculating age, the research assistants asked about the relevant festival based on the religion of the participant. However, in the urban set-up the date of birth is mostly the sole reference point for the calculation of age. In the case the women, age was estimated by summing age at major life events in order to enable the most proximate estimation.

In Bangladesh, the reference points used for the estimation of age are the major political and ecological events such as the liberation movement of Bangladesh in 1971 and natural calamities such as flood and drought. The identification number assigned by the DSS such as Bari code, current identification number (CID) and registration identification number (RID) was used to identify the selected sample from the six selected villages of Matlab, Bangladesh.

In both India and Bangladesh, the birth certificate and immunisation certificate of the child was used for recording the child's age. In both India and Bangladesh, the doors of the enumerated households were marked during the complete coverage in order to identify households in the latter phases of data collection.

Mapping

In India and Bangladesh, maps are essential for conducting research because these were needed to locate selected respondents of the research. In the absence of formal maps[13] at the village and ward level, maps were drawn by the enumerators with the help of people native to the research location. Additionally, religious spaces such as temples and mosques were to be plotted in the maps hence drawing our own map became essential. Basic infrastructure in the villages and the urban ward such as water tank, bore well, public spaces such as the *panchayat* (local self-government), educational institutions, *anganwadi* (kindergarten) and health centres were plotted on those maps. Maps of the six villages in Matlab, Bangladesh, were made available by the collaborating institute HDSU, ICDDR, B based on the GIS database for the present research.

[13] Hand-drawn maps at the village and ward level are made available by the census; however, they are crude illustrations.

2.14.2 Second Phase: Qualitative data collection

Qualitative data were collected from the participants of the present research through in-depth interviews and key informant interviews. Visual data of religious symbols in the households and those adorned by people were also collected.

In-depth interviews

The research topic was first introduced to the participants and their consent was obtained before starting the interviews. The in-depth interviews were conducted within a span of 75 minutes to 90 minutes. In qualitative research, the interviewer acted as the main research instrument of data collection because of the utmost amount of tact required to establish rapport with the participant. In order to cruise through the crucial themes of the research, the interviewer created a comfortable atmosphere for the participant to open up and talk about personal issues such as childbearing. The interviewer also was attentive to touch upon issues of interest for the research and also was careful not to pose the questions in an assertive manner. Another crucial aspect of conducting in-depth interviews was the ability of the interviewer to identify new and interesting information that is given by the participant. During the training programme, the PI trained the research team in the nuances of the techniques mentioned earlier. Additionally, during the interview if the research assistant posed any particular question in an inappropriate manner, the PI brought that to the notice of the research assistant. The PI and the research assistants discussed the main points from the interview after each interview was completed. Such discussions enabled the research team to improvise on the interviewing skills and also to modify the approach towards specific questions. The meetings after the interview were also meant to discuss the non-verbal responses such as body language, facial expression and pauses from the participants of the research.

Several strategies were developed in order to facilitate a non-intrusive environment for conducting in-depth interviews. The interviews were held within the house of the

participant at a place where the participant was comfortable. In order to record the interview, a place with the least amount of disturbance was chosen.

At times, the presence of in-laws or husband at the interview site was distracting for the participant as they were curious about the questions being asked. It has been observed that in a few instances they tried to prompt the female participant or answer on her behalf. In such circumstances, the interviewer informed the curious family members to allow the participant first respond on her own and later they might be asked for their opinion. In a few instances, if the relatives or acquaintances continued to interfere in the interview, another research assistant started a parallel conversation with them. The PI was present during all the in-depth interviews with females and most of the Muslim female participants were interviewed by her. She also closely monitored all other interviews. The male participants were first contacted in the places where men get together after work such as the tea shop, community centre, *panchayat* (local self-government) office and so on.

Certain modifications were carried out during the course of data collection in view of the various situations that arose. For instance, it was first planned that the in-depth interview would be conducted in two sittings in view of the extensive nature of interview guidelines. However, in the rural context during the harvesting season the participants were often involved in agricultural work to process the harvest in the agricultural fields or their homes. This resulted in some participants dropping out in the second sitting of the interview. Thus, it was later decided to complete the interviews in one sitting by taking sufficient intervals in between the interview. Another instance of such modification during the course of data collection was the sequence in which questions were posed to the female participants. The questions in the interview guidelines were first arranged in the sequence of the life cycle, e.g. marriage, childbirth, breastfeeding, contraception, and abortion. However, it was observed that the topic of contraception and abortion was not appreciated by a few participants especially in the first half an hour of the interview. Hence, these topics were approached at the end of the interview.

Visual Data

The present research also focussed on exploring the religious symbols that are attached to Hinduism and Islam. The religious symbols were captured through the visual medium of photography. Examples of such were religious centres such as temples and mosques; symbols worn by married women and children, pictures of gods/goddesses and religious inscriptions in the participant's home.

2.14.3 Third Phase: Survey data collection

The primary sampling unit (village and ward) for each research location was selected based on the religious (Hindu and Muslim) composition of the specific site. The survey data were drawn from a sample of 800 currently married women (400 each from India and Bangladesh) in the reproductive age group of 18-44 years. In each country, the sample consisted of 200 respondents from urban areas (100 Hindus and 100 Muslims) and 200 respondents from rural areas (100 Hindus and 100 Muslims).

A two-stage sampling procedure was followed in the rural areas and a three-stage sampling procedure was adopted in the urban locations. In the first stage, the primary sampling unit of the rural location, i.e. village, was selected. In the second stage, a systematic random sampling procedure was used to select the sample household from the baseline information. In the first stage, the primary sampling unit of the urban location, i.e. ward, was selected. In the second stage, a census enumeration block was randomly selected from the urban ward in question. In the third stage, a systematic random sampling procedure was used to select the sample household from the baseline information. Furthermore, since the two religious groups are not evenly distributed, it was not possible to draw a uniform sampling fraction for both communities in each research location. Consequently, in each setting, a separate list was drawn for Hindus and Muslims. Based on the list, sampling fractions for each of the religious group was separately calculated.

Drawing equal samples for both communities was challenging in rural locations of both countries because Muslims in India and Hindus in Bangladesh (religious minorities in the respective countries) are relatively more concentrated in urban

locations. Despite over-sampling for the minority communities (Muslims in India and Hindus in Bangladesh) in the rural locations, it was often observed that people migrated out of the villages and if they were absent and it was challenging to approach the required sample size.

After the sample was drawn for the survey, the research assistants were given the sample list with addresses and a target was set regarding the number of questionnaires to be administered on a daily basis. However, the daily target was kept flexible in order to maintain a better quality of the data. Each questionnaire was filled within a time span ranging between 40 to 60 minutes. Prime attention was given to explaining clearly the exact meaning of each question. Many a time the same question was phrased in a different manner till the participant understood the exact meaning of the question. The response categories in the questionnaire were not prompted and the participants were encouraged to answer on their own. The category "other" was included as a response option for many questions on the questionnaire in order to obtain a variety of responses to the different questions.

Observation

Religious symbols were observed and noted in the questionnaire. The symbols were religious artefacts worn by married women, children and religious symbols present in the house. In the case of Hindu women in India the symbols noted were *kalungara* (toe ring), *tali* (necklace worn by married women), and thread on hand/neck. The religious artefact noted among Muslim women in India is *laccha* (a necklace worn by married women). In Bangladesh the symbols noted among Hindu married woman were *sakha* (sea shell bangles) and s*idoor* (vermillion on the forehead). Other common symbols observed were t*aviz* (capsule worn on arm to ward off evil). In India, children wore bracelet or chain made from thread. Further, in Bangladesh, children were observed wearing thread around their waist. Pictures of Gods, framed inscriptions and statues of gods were noted in the households of participants in both countries.

Anthropometric measures

In order to assess the nutritional status of women, anthropometric measurements of height and weight were recorded. The height of women was recorded in inches and weight in kilograms. Unitary scale was used to measure the weight of women, which has a precision of up to 500 grams.

2.15 Data Management

The following section elaborates the labelling of qualitative data, transcription and translation of qualitative data and editing of quantitative survey data.

2.15.1 First phase: labelling of in-depth interviews

The in-depth and the key informant interviews were categorised into various domains, such as country (India and Bangladesh), location (rural and urban), religion (Hindu and Muslim), gender (male and female), age (completed age) and education (number of years of schooling). In order to identify each interview based on these background features, the voice files of the interview and the transcripts were assigned labels for example, ID19HO10 means that the interview was conducted in India (I), Dharwad (D), the respondent is 19 years old (19), is a Hindu (H), belongs to the Okkaliga caste (O) and has completed 10 years of education (10). Separate folders were maintained for male and female participants.

2.15.2 Second Phase: transcription and translation (in-depth interviews)

After the in-depth interviews were conducted, the following processing was done. First, transcribing the interviews in the native language. Second, translating the native language transcripts into English. The interviews were trans-literated in order to keep the text close to the views of the participants. In Bangladesh transcription and translation were done by the same person; however, data processing of few interviews in India was shared between a transcriber and a translator.

2.15.3 Third phase: survey data editing

The questionnaires which were used in the survey were first screened to determine whether all the relevant questions have been answered. Missing cases were identified

and the data was checked for discrepancy. In order to ascertain the quality of the data checks were carried out for the logical order and skip questions was done. In case the information collected lacked clarity the research assistant was asked to clarify the same. In some instances, the research assistants had to follow up the questionnaire by visiting the respondent in case there was missing information or the data needed some cross-checking.

2.16 Comparative coding of survey data

Before administering the questionnaire, a master code plan was prepared based on the response categories that were assigned for each question in the questionnaire. After the data was collected, the questionnaire was screened for open-ended options under the "other" category. Further, the "other" category was also coded. Thereafter the responses to the "other" category were translated into English. The responses, which were similar to the previously assigned code but were expressed differently, were recoded. The answers to open-ended questions were coded and a final draft of the coding plan was prepared. The data entry operator wrote a program based on the final code plan. The data entry software - CSPro version 3 - was used for entering the data. This software allows for the consideration of shift questions in the questionnaire minimising the chances of making wrong entries while entering the data.

The coding in the Bangladeshi questionnaire is similar to that of the Indian questionnaire. The Indian code plan served as the reference point for Bangladesh code plan. However, the context of Bangladesh differs from that of India. Thus, several changes had to be incorporated into the Bangladeshi code plan. A new master code plan for Bangladesh was prepared before the contextualised questionnaire was administered. Furthermore, the new code plan was revised and edited after the data collection was completed. Considering the contextual changes which were made in the Bangladeshi code plan, a new data entry program file was prepared for Bangladesh. The data from Bangladesh was then entered according to the new code plan.

2.17 Lessons learnt through comparative research

The lessons that were learnt in this present comparative research that involved a mixed-method research design are related to the challenges that were faced during the collection of data, data coding and management. The following suggestions are made in the event that similar research is conducted again.

The first suggestion is to complete the collection of qualitative data in both countries and based on the inputs from qualitative research the survey research instruments should be contextualised. This ensures that the different concepts used in the research are standardised before the survey data collection commences. Such standardisation is extremely essential in conducting comparative research. By developing a master code plan which includes all contextual differences of all comparative settings will economize time and energy. This will also result in clarity of concepts from the beginning of the research and pave a clear direction for the survey data collection.

The processing and analysing of data in the present research became cumbersome because there are two versions of the code plans for both the countries. Hence, the data were entered according to the two different code plans. A solution that can be suggested in this regard is to develop a uniform code plan which takes contextual differences into account and to conduct the data entry of both countries together based on the uniform code plan.

Chapter 3: Situating the researcher's identity and researching on identity

3.1 Introduction

The researcher's personal identity and its implication for the process of data collection and analysis remain rather evasive in the texts of social science research (Sherif 2001; Springwood and King 2001). The silence over the researcher's positionality in the social science text is an offshoot of epistemological parallels that are drawn from the natural sciences into the realm of social sciences. Post-structuralism is critical of this notion of a social researcher, projected to be detached, scientifically neutral and objective (Fine 1994; Kanuha 2000). The epistemological basis of the natural sciences is different from that of the social sciences. Thus, the understanding of a concept such as objectivity in the former does not find application in the latter (Nightingale 2003). The identity of the researcher in the social sciences becomes especially important when data collection is characterised by face-to-face interaction. It becomes additionally important to be reflexive regarding the researcher's positionality in the field when the social construct under investigation is also a part of a researcher's personal identity. A social science researcher is an embodiment of multiple identities such as nationality, gender, race, religion, language and so on, which get reflected in the conceptualisation and implementation of the research problem. This linkage between the personal identity of the researcher and that of the participants of the research is described by Fine, (1994: 72), as "the self and the other are knottily entangled".

The identity of the researcher gets reflected on the methodology used during data collection (Lather 1991; Anderson 1994; Hermes 1998) and eventually on the information collected. When the researcher does not address self-identity in qualitative research it suggests an implicit assumption that the identity of the researcher does not or should not matter (Kanhua 2000). By maintaining silence over the interface of researcher's identity with that of researched, the researcher fails to inform the reader of an important subtext of qualitative research, i.e. the manner in which the researcher's identity has been negotiated in the field. There is a need to be reflexive regarding the researcher's identity during the research process because it gives a critical nuance to the research by complicating the insider-outsider dichotomies (Bank 1998; Vo 2000; cf. Subedi and Rhee, 2008). Such reflexivity becomes extremely crucial in research dealing with race, ethnicity, minority, and gender issues because these constructs are primary identifications for the researcher as well as the researched. Being reflexive is also about being visible and accountable of how the research has been conducted (Stanfield 1993) and acknowledging the limits of the researcher's purview (Narayan 1993). Similarly, it is equally important to reflect on the negotiation of representation, power and difference by the researcher (Subedi and Rhee, 2008). This means that there is a need to etch out a clear picture of what is "happening in between the self and the other" (Fine 1994:72). Researchers who have worked on the same have used notions such as "hyphen" (Fine 1994; Wagle and Cantaffa 2008), "halfie" or "in between" (Narayan 1993; Subedi 2006) to demonstrate the researcher's positionality.

By working on the hyphen and not just the other, Fine (1994: 72) reasons
"We probe how we are in relation to the context and with our informants, understanding that we are multiple in those relations".

In drawing the contours of this chapter, first, the varied religious, linguistic and nationalistic dimensions of the comparative research in India and Bangladesh and the researcher's personal identity are elucidated in order to prepare a basis for the

discussion that follows on self-other negotiation. Second, in order to select the construct for situating my (principal investigator) positionality, I will juxtapose the native/non-native dichotomy with the construct of shifting identifications. Third, I will primarily situate my personal identity and latently, that of the research teams involved in data collection, and discuss its implications for the researcher/researched discourse. Fourth, I will reflect on the strategies of representation I used in the comparative research settings. Fifth, the resonance of my personal identity on the research is critically analysed.

3.2 Background of the research and the researcher

The objective of the present research is to explore the role of religion, minority status and agency on reproductive behaviour in India and Bangladesh. The focus of this research is primarily on two religious communities, namely Hindus and Muslims, in a comparative context of India and Bangladesh.

In the South Asian region, Muslims constitute a religious minority in India (13.4 percent) and a majority in Bangladesh (87.8 percent); Hindus are a majority in India (80.5 percent) and a minority in Bangladesh (9.3 percent). The unique nature of the religious composition in India and Bangladesh allows the testing of certain demographic research hypotheses. However, the comparative nature of the research (Hindu and Muslims; India and Bangladesh; majority and minority) also has important implications for the self-other negotiation during data collection which I will to address in this chapter.

The present research project is situated within the discipline of demography, which is a discipline that is known to primarily rely on quantitative methods. However, the present research combines both qualitative and quantitative methods to address the research objective mentioned earlier. This chapter will primarily focus on the self-other negotiation while using the qualitative method of interviewing religious minorities, i.e. Hindus in Bangladesh and Muslims in India. Out of 48 in-depth

interviews conducted among Muslims in India and Hindus in Bangladesh, three interviews have been cited in this chapter for illustration.

The two religious minority groups, namely Muslims in India and Hindus in Bangladesh, not only differ by religious affiliation but also by language which further complicates the self-other negotiation in the present research. Hence, it becomes crucial to elaborate in detail the linguistic genealogies of all languages involved in the present research in order to prepare the background for the discussion that follows. The fieldwork in India was conducted in rural Dharwad and urban Bangalore in the state of Karnataka. The fieldwork in Bangladesh was conducted in rural Matlab and urban Dhaka. Kannada is spoken by the Hindu majority in the state of Karnataka whereas Muslims there speak Dhakani. Generally, Muslims in India speak Urdu; however, in Karnataka they speak a dialect of Urdu known as Dhakani. The Hindus and Muslims of Bangladesh speak a dialect of Bangla which is known as the East Bengal dialect.

The study groups of the present research are religious minorities who often constitute a marginalised section of society due to the unequal power relationship; thus, it becomes all the more important to be explicit about the researcher's identity from the ethical point of view (Harrison 1991). Therefore, I (principal investigator) will elaborate on my personal identity. I am an Indian from the southeastern state of Orissa. I am a single Hindu woman and I am native speaker of the language Oriya. Currently, I am pursuing a PhD degree from a university in The Netherlands.

3.3 Characterisation of researcher's positionality

A researcher's positionality in the field is often characterised by the native and non-native dichotomy. A native researcher is one who conducts research with a group that he/she identifies with (Kanuha 2000). However, the use of a native/non-native dichotomy to characterise a researcher's positionality is rather problematic (Narayan 1993) and limiting because a researcher is positioned across several cross-cutting identifications (Rosaldo 1989; cf. Narayan 1993). Furthermore, due to the

comparative nature of the current research, the use of native/non-native dichotomy is not an adequate characterisation of my positionality in the field. Rather, I consider the construct of "shifting identifications" (Narayan 1993) to be an appropriate characterisation of my positionality in the field. The construct "shifting identification" assigns a certain degree of fluidity to my positionality in the field, defining my personal identity in relation to the varied cross-cutting identifications of research participants in the present comparative research. The mixed racial and geographic positionality of Narayan (German-Indian-American) has made her reflect on "shifting identities", arising from her own experience of collecting data in India. Narayan (1993) maintains that for conducting fieldwork in India "someone who is fully Indian by birth and upbringing" may not have a stable identity in the field. This observation by Narayan aptly describes my fieldwork experience because India is so culturally diversified in terms of religion, language, and so forth that my identity would be characterised as shifting even while interviewing a group with whom I share a common nationality and religion. Having a stable identity means that there is a commonality between the researcher's personal identity and the research participants, and for the research process this means that the researcher is aware of the structural and normative make-up of the group that is being studied. This knowledge of the normative set-up creates an equally important academic challenge, which is that of distancing oneself from one's own identity group. Furthermore, if the researcher is an insider to the group the research procedure might get compromised if the researcher overlooks the "taken for granted" dimensions of group behaviour (Hayano 1979; cf. Kanhua 2000). The researcher needs to be attentive to these possible pitfalls while addressing self-other negotiations during fieldwork and the researcher should develop appropriate strategies in order to avoid those pitfalls in the research process. In this comparative research, the aspect of my identity that has remained stable throughout the fieldwork is my South Asian appearance, which has been perceived as both Indian and Bangladeshi by the research participants. Venkateswar (2001) emphasises the relevance of a researcher's appearance for the construction of identity during fieldwork.

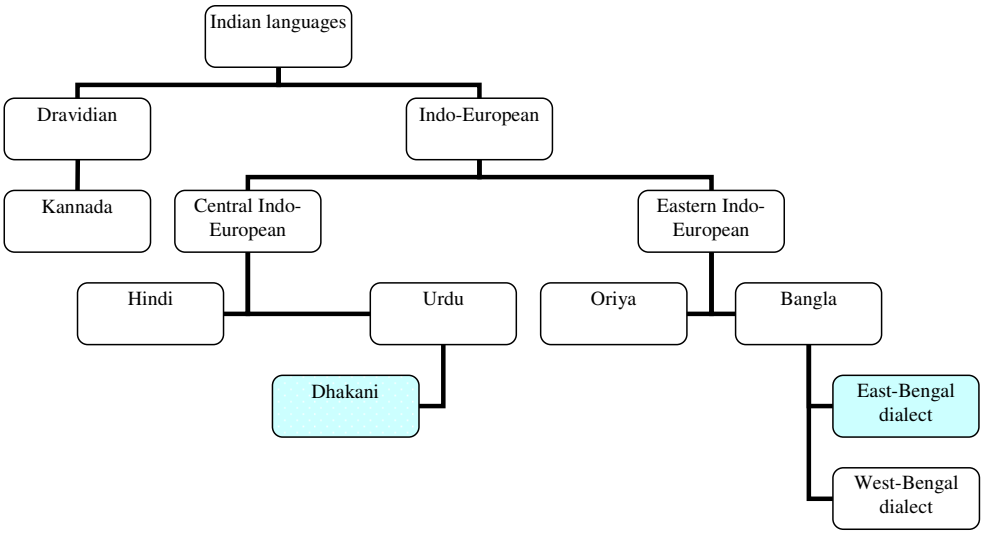
In order to address the self-other negotiation in my fieldwork experience in India and Bangladesh, I will first situate my *self* (primarily my personal identity and implicitly that of research team members) along the range of identifications such as language, gender and religion in relation to the *other* (research participants).

3.4 Situating the Principal Investigator (PI) and the team in India: religion, language and gender

The Indian research team members are primarily Hindu. For the research process, it means that the interviewers are from the religious majority community, which makes them outsiders for the Muslim participants in the research. To enhance rapport building with the Muslim participants in the field it was considered appropriate to recruit an interviewer who is affiliated with the same religion. However, attempts to recruit a Muslim research assistant did not materialise due to contextual reasons. First, all applicants for the position of research assistant in India were Hindu, primarily because they are numerically preponderant. Second, an attempt to recruit a female Muslim research assistant did not materialise in India because Muslim women have restricted physical mobility due to Islamic gender norms. Further, the nature of work in the present research at times necessitated the female research assistant to work in the evening. This was not acceptable for the family members of the Muslim females who were short listed for the research team.

A linguistic divide between North and South characterises the Indian cultural context. The Indian languages can broadly be categorised into Dravidian or South Indian languages and the Indo-European or the North Indian languages. Figure 3.1 elaborates the linguistic genealogy of the Indian languages that are relevant for the present research.

Figure 3.1: Linguistic genealogy of Indian languages



The Dravidian languages are broadly categorised into four languages. However, I have included only Kannada in the figure due to its relevance for this chapter. Additionally, there is a linguistic dimension to religion in Karnataka, namely Hindus speak Kannada - a Dravidian language - and Muslims speak Dhakanin - an Indo-European language. As a Hindu, I am an outsider for the Muslim research participants in India; however, linguistically, I am somewhere close to an insider to them because my mother tongue Oriya and the national language of India – Hindi - in which I interviewed the Muslim participants belong to the same linguistic family as Dhakani, i.e. Indo-European.

The in-depth interviews were to be conducted among both male and female participants. I along with the female research assistants interviewed the female participants and male research assistants interviewed the male participants. The gender consideration of the research team was maintained in view of the strict gender norms characteristic of the South Asian context. This gender divide in the research team was beneficial to the research team to build better rapport with the participants

especially in administering culturally sensitive questions. In the South Asian context there are often limitations placed on a woman's social interaction with a man who is not related to her by blood or marriage. Hence, we (PI and the female research team) could convince the "gatekeepers of the family" to allow the female respondent to participate in the research.

My observation through extensive data collection in Karnataka is that most of the Muslim women in urban Bangalore can speak only one language, i.e. Dhakani, whereas the Muslim men in the same location speak Dhakani as well as Kannada - the language of the Hindu majority. I consider the inability of Muslim women in Bangalore to converse in Kannada to be an offshoot of the typical residential settlement (concentrated residential pockets) of Muslims in Bangalore (see chapter 6). The Muslim minorities are segregated from the Hindu majority, specifically women due to gender restrictions and residential segregation. This has resulted in a linguistic isolation of Muslim women from the majority community. Hence, I interviewed the female Muslim participants in Hindi - the national language of India and a language close to Dhakani. By contrast, the Muslim men in Bangalore - because of their involvement in economic pursuits - have a greater interaction with the Hindu community and can converse in Kannada. Hence, the Muslim male participants were interviewed in Kannada by the male research assistant.

3.5 Situating the Principal Investigator (PI) and the team in Bangladesh: religion, language, gender and nationality

The research team in Bangladesh was composed of members from mixed religious backgrounds - I am a Hindu and the two research assistants are Muslim. During fieldwork in Bangladesh, in addition to my religious and linguistic identity, I had to negotiate my identity as an Indian. My Indian identity made me an outsider to the Bangladeshi Hindu participants. However, at the same time my Hindu identity made me an insider to the Hindu participants. I interviewed most of the Hindu participants and the Muslim research assistants interviewed the Muslim participants.

In Bangladesh, both the Hindu and Muslim communities speak Bangla. Bangla is not my native language; however, it is important to add that Oriya (my mother tongue) and Bangla belong to the same linguistic sub-family i.e. Eastern Indo-European language family (refer to figure 3.1 for elaboration). This common root of both languages enabled me not just to understand Bangla but also to effectively communicate with the participants of the research and the research team. In addition to the common linguistic root between Bangla and Oriya, I was also exposed to Bangla in my growing-up years through friends and neighbors who were native speakers of that language. The dialect of Bangla that I was exposed to then was the West Bengal dialect spoken in the state of West Bengal, a neighbouring state of Orissa. Until partition of India in 1947, Greater Bengal consisted of West Bengal and East Bengal (now Bangladesh). The dialect spoken in Bangladesh is known as the East Bangali dialect. It took some time and effort for me to understand the nuances of the dialect and word usage. However, because of the close affinity between my mother tongue Oriya and Bangla, along with my early exposure to the language, it was relatively easier for me to communicate with participants of the research and research team in Bangladesh. I along with the research assistants conducted the interviews in Bangla; thus, we were linguistically insiders for the participants in Bangladesh.

3.6 Strategies of representation

The comparative nature of the present research made it impossible for me to have a stable identity with the participants of this research. However, in order to establish rapport, I have used certain strategies of representation with each group of the study participants i.e. Muslims in India and Hindus of Bangladesh. For instance, while representing myself in the field, I have accentuated facets of my personal identity which are similar to that of the study participants and at the same time I have played down facets of my personal identity that differed.

Linguistic identity is treated synonymously with religious identity by participants of this research in Karnataka where Hindus and Muslims speak different languages. The

process through which the Muslim community retains its distinct identity in Karnataka can be described as boundary maintenance (Smith 1989). Boundary maintenance signifies a process through which either group tries to maintain a distinct identity and ensures that there is least similarity of behaviour between communities (Barth 1969). In the process of boundary maintenance symbols play an important role to generate a sense of shared community belongingness (Cohen 1986). For instance, Muslims retain their distinct Dhakani-Urdu-speaking identity by identifying Hindus through their linguistic affiliation which differs from theirs by referring to them as "Kannad" (one who speaks Kannada).

In my attempt to accentuate similarity between the self and the other, I played down my Hindu identity by representing myself as an Oriya (native speaker of Oriya) to the Muslim female participants. Further, Kannada being a marker of Hindu identity in Karnataka and the fact that I am not a native speaker of that language, I decided to introduce myself as an Oriya. My introduction as an Oriya is a strategy which neutralises my Hindu identity - a point of differentiation for the Muslim participants. Additionally, I spoke to the Muslim participants in Hindi (national language of India). As indicated earlier (see Figure 3.1) both Hindi and Urdu belong to the Central Indo European linguistic family. This was another strategy to accentuate similarity between the self and the other since both the languages share linguistic roots. Highlighting that I am not a Kannad (synonymous with Hindus) and by being fluent in a language close to the one the Muslim participants speak was key in establishing rapport between the self and the other. In this process of representation, my linguistic identity took precedence over my religious identity. I conducted most of interviews with Muslims in Hindi. I consider my positionality in the field in relation to the Muslim participants in India to that of an "in-between status". This in-between status is a result of me not being co-religionist (a Hindu) with the *other*; while at the same time sharing linguistic roots with the *other* (Hindi, Oriya and Dhakani belong to the Indo-European linguistic family).

Given the geographic and cultural proximity between Orissa and greater Bengal, I found myself in a more familiar "field" in Bangladesh than in India. The cultural parallels of the two regions are not confined to language alone but also with regard to the gender norms, beliefs, mannerisms and etiquettes. In order to accentuate the similarity between the self and other, I introduced myself as a Hindu to the Hindus participants of Bangladesh. However, my introduction as a Hindu did not require me to clearly pronounce my religious identity because my name itself is suggestive of my religion. Hence, I pronounced my name clearly while introducing myself to the research participants. I further accentuated my familiarity with the Hindu participants by introducing myself as a resident of Puri (a Hindu religious pilgrimage centre known as *dham* in Orissa, India). The place Puri is immensely revered by Hindus across borders, which immediately brought about a religio-spatial point of reference for the Hindus of Bangladesh. This religio-spatial familiarity gave me the opportunity to further intensify the rapport. Several Hindu participants had already visited Puri and had anecdotes of their visit, which they shared with me. This familiarity of the religious space of Puri, the similarity of religious affiliation and my knowledge of Bangla gave me the status of an "almost - insider" with regard to the Bangladeshi Hindu participants of this research. The diffused nature of my positionality was evident when participants would invariably assume that I was Bangladeshi and be surprised at the revelation of my nationality and react: "you look Bangali (appearance) and speak Bangla (linguistically) so it is hard to differentiate *you* from *us*". Additionally, in the past and also recently, there has been large-scale migration of Hindus from Bangladesh to West Bengal in India. Several participants of the research had relatives in West Bengal. Thus, after getting to know that I am a Hindu from India, they often made me the site of information regarding India and would clarify their notions and impressions of West Bengal in India. This gave me another opportunity to build rapport with the participants of the research.

Considering class privilege that is inherent in the South Asian context and its relevance for the construction of the researcher's identity (Venkateswar 2001), I

decided to play down facets of my personal identity such as my university education and social class (middle class), specifically while interacting with low-educated and poor women. As an Indian, I know that an educated and city-bred woman dressed in Western clothes who might want to interview a rural and less-educated woman, might face a hurdle in building rapport. Dressing up differently from the research participants makes the visual differences between self and other more apparent. Furthermore, the participants by being aware of their unequal position compared to that of the interviewer might hesitate to share certain information which they might consider inappropriate to disclose. In order to neutralise our educational and social class background, I along with the other female assistants wore *salwar kamij* (Indian traditional attire consisting of a long shirt, pants and a scarf to cover bosom) throughout the fieldwork. I decided to wear my hair long and plait it because it is a very common hairstyle in the study location. It was my intention to keep our look traditional because it was a means to exemplify the similarity between the self and the other.

To summarise the argument up to this point, the relevance of the researcher's personal identity for negotiating rapport with the research participants is worked out by situating my identity and that of the research teams across the comparative plane. Strategies used for representation reflected my attempt to accentuate similarity between the self and the other. Different strategies were adopted, based on the nature of the research context. In the present research, strategies of representation have been thought through and worked out in detail before approaching the research participants. The following section delineates the role of the researcher's personal identity on the research process at two levels: (a) revealing personal identity and its implications for interviews (b) resonance of difference.

3.7 Role of researcher's personal identity on the research

To establish rapport with the research participants, I attempted to magnify the similarity between the self and the other; however, there have been instances when the differences between the self and the other were also apparent.

3.7.1 Revealing personal identity and its implication

I was explicit about my religious identity in India by wearing a *bindi* (dot worn on the forehead by Hindu females). The two female research assistants in India, in addition to wearing a *bindi* also wore a nose stud on the left nostril signifying that they are Hindu. Muslim women wear it on the right nostril. In Bangladesh, the demarcation of religious visual symbols is rather blurred because a *bindi* alone does not signify the religion to which one is affiliated. Both Hindu and Muslim women in Bangladesh can be seen wearing *bindi*. I decided not to wear a *bindi* in Bangladesh because my wearing it or not does not make any statement regarding my religious identity. Revealing the research team's personal identity, which is different from that of the research participants, resulted in some confronting situations, which I will illustrate in the following section.

Before approaching a prospective female participant in India and Bangladesh, the research team was often required to first convince the gatekeepers of the household, namely her husband and in-laws. In addition to approval from the female respondent, the gatekeeper's approval and perception of the research team were very crucial to ensure participation of the female respondent. To illustrate this, I will cite some instances which we confronted in the field. For instance, a female Muslim participant's husband in urban Bangalore, after knowing that the research team was composed of Hindus, aggressively opposed the participation of his wife in the research. He said his opposition stems from his perception that all Hindus stereotype Muslims as terrorists so he will not allow the research team to interview his wife unless the research team clarifies its stand regarding Muslims. In another instance, after interviewing a female participant in Bangalore, her husband confronted the research team the following day and questioned the purpose of the research in a hostile manner. He even threatened the research team to leave the area and said "some people like you (Hindu) had come to our community before and they did things which they should not have done and eventually did not meet good consequence". The reason for such hostile reaction, as I infer, is the sensitivity of the relationship

between the Hindu and Muslim communities which stems from prior instances of clashes between both communities. Additionally, because of the changing geo-political situation after 9/11 and other bomb blasts in India, stereotyping the Muslim community as terrorists and viewing them with suspicion has become commonplace. Consequently, in several instances the research team had to justify that the purpose of the research was purely academic and that the research team members have a neutral stand towards Muslims especially to the gatekeepers of the household. These encounters were confrontational and were a stressor when the gatekeepers of the Muslim households of the Indian study locations were approached.

In India, especially in the rural areas, talking about reproduction or sexuality is culturally accepted only when the people concerned are married. The female research team was explicit regarding their single status and they refrained from adorning any symbols of marriage such as the *mangalsutra* (necklace) or the *kalungra* (toe ring), both symbols of Hindu marital status in Karnataka. Given the cultural context of the research location and the unmarried status of the female research team, researching the issue of reproduction gave rise to some unexpected encounters. For instance, in rural Dharwad, the mother-in-law of a female participant asked the researchers to discontinue the interview and to come back later because the participant had to attend to some urgent work. The research team visited the house of the participant on several occasions to resume the incomplete interview. However, we were sent back every time because the daughter-in-law was either busy or away. Later, through a reliable source, we gathered that the mother-in-law of the female participant did not approve of unmarried females asking her daughter-in-law about contraception. Because of this, she did not allow the research team to complete the interview. Culturally, it is also not acceptable to express such disapproval directly to the "guests" (anyone who visits a home is considered a guest and one is obliged to be cordial) in a straightforward manner; thus, the mother-in-law of the participant was tacitly trying to put a closure to the interview.

In Bangladesh, I was explicit about my unmarried status because I did not wear *sakha* (seashell bangles) and *sidur* (vermillion on the forehead), both symbols of Hindu marital status. However, my unmarried status worked in my favour in some cases. For instance, the female participants were sympathetic towards me because I was unmarried despite "being of marriageable age". They were surprised and sorry to know that I had come to work in a foreign country "unaccompanied". In fact one of the female participants agreed to participate because she was empathetic towards my "state" (unmarried and unaccompanied). She mentioned that since I had come all alone from another country to listen to her story, the least she could do was to give me an interview.

3.7.2 Resonance of difference

The section on the strategies of representation demonstrates my attempt to magnify similarity between my personal identity and that of the participant as a means of establishing rapport. However, in this section, I will dwell on the differences between the self and the other and its resonance in the information that is collected.

The participants of the research were aware that their personal identity differed from that of the researcher's personal identity, which reflects their awareness of the "other" in the interview. Excerpts of the interview will illustrate this. The local languages (Dhakani in India and Bangla in Bangladesh) used are cited verbatim and later translated into English. This is done in order to ensure that the translated English text remains close to the flavour and meaning of the opinion expressed by the participant in their local language.

I: Abhi jo aap yeh sab palan kar rahi hain na, kya aapko yeh lagta hai yeh sab apke samaj mein rehni chahiye?
P: Rehna to sahi baat hai.
I: Kyon rehna chahiye?
P: Kyonke hamara majhab toh wohich hai.
I: To aap majhab ko kaise mante hai? Kya apko karna hi hai?
P: Karna hi zaroori hai.
I: Wohi zaroori kyon hai?
P: Kyonki hum mussalman hai. Allah mia humna mussalman karke banaya. Paida kiya. Agar che humna bhi tumhare isme paida kiya rehta toh…..
I: toh
P: humna bhi tumhari tarah nahin karte. Allah accha kiya ke humna mussalman karke paida kiya. Woh hoosh karke, khayal karke humna mussalman banaya karko humna majhab mein kya hai woh karna zaroori hai.

I: The religious practices that you follow, do you think they should be followed?
P: It should continue because it is right.
I: Why is it right?
P: Because it is our religion.
I: So you believe that it should be followed?
P: Yes, it is necessary.
I: Why is it necessary?
P: Because we are Mussalman. Allah has made us Mussalman by birth. If he made us to be born in your religion then …….
I: Then?
P: Then, we would have not done any of these (religious practices). Allah has done the right thing by giving us birth as Mussalman. Allah has been considerate enough to make us Mussalman; thus, we should follow whatever is prescribed in our religion as it is necessary.
(Participant 1: 22 years of age, Female, Muslim, four years of education, Dharwad, India, Language: Dhakani)

The cited excerpt indicates that the Indian Muslim participant, in order to clarify her point, has made references to the interviewer's religious identity as a Hindu. She feels grateful to Allah that unlike the interviewer she is born a Muslim which for her holds greater relative importance.

> I: Aapke hisab se jab ladke ko shadi karna hai, ladki mein kya dekhte hai?
> P: Ladki ko puchte hai padhke hai kya? Quran padhi kya? Kapda siti kya? Saal sikhke hai kya? Sikha to sikha bolti, nahin to nahin bolti hai. Tumhara Hindu mein kaisa hai na.
> I: Jaisa?
> P: Kannad ladka naukri karta toh choori sikha sali hona mangta. Waise humare Urdu mein bhi hai.
>
> I: According to you when a boy has to get married, what does he look for in a bride?
> P: They ask the girl whether she has studied. Has she read Quran? Does she know how to sew clothes? Has she gone to school? If she has studied then she says yes, if not then she says no. It is like among you Hindus.
> I: Like?
> P: When a Kannad boy has a job he wants his bride to be educated, in a similar manner among us Urdu-speaking people.
> (Participant 3: 24 years of age, Female, Muslim, *madrasa* educated, Dharwad, India, Language: Dhakani)

The Muslim participant makes references to the parallels between the interviewer's (Hindu) community and her own (Muslims) community with regard to the qualities that are expected of a potential bride. The participant also indicated the religio-linguistic synonymity in Karnataka, India, where she refers to Hindus as Kannad - and Muslims as Urdu - or Dhakani-speaking people.

> I: Eeei dui dharma moddhe kichhu mel acche?
> P: Dharma kichu achar anusthan chada sab mel.
> I: Sab mel?
> P: Haan.

I: Kan kan bisoye ektu explain koren?
P: Eeidekhchen je khava dava. Apnar de moddhe gorur manso ta khaye amader bhitore khaina. Anek acche je suarer manso tanso khaye, amra kintu kakhono khaini. Apnar moddhe eei sab haram tai na? Amader modhe puja kori apnnader modhe Eid. Eei sab chada to amra sab manus.

I: Is there any similarity between the two religions?
P: Barring some religious aspects, all other things are similar.
I: Everything is similar?
P: Yes
I: Can you please explain in which matters there is similarity?
P: Food habit. In your community you eat the meat of cow but we do not eat that. Some people among us eat the meat of pig but we have never eaten that. For you people it is *haram* (not accepted) isn't it? We have *pujo* (Hindu festival) but you people have *Eid* (Muslim ritual fasting in the month of Ramadan). Apart from this we all are human beings.
(Participant 4: 25 years of age, Female, Hindu, Master of Arts, Dhaka, Bangladesh, Language: Bangla)

I:*Purdha* prachalan ta ka der moddhe besi?
P: Apnader moddhe to purdah prachan besi. Baire je jabo …subhida moton jabo ammo kintu apnader modhe eita ke pocchondo nahin karum.

I: Who maintains *purdah* (practice whereby women are required to cover their body and are restricted in their movement) more?
P: Among you people the practice of *purdha* is more. When it comes to going out I go and come at my convenience but your community does not approve this.
(Participant 5: 33 years of age, Female, Hindu, illiterate, Matlab, Bangladesh, Language: Bangla)

In Bangladesh, the Hindu participant explained the similarities and differences between Hindus and Muslim community and refers to the interviewer's religion (Islam) to illustrate her point that Hindus and Muslims are similar in all matters

except for difference in food, rituals and religious festivals. The second Hindu participant, wanting to emphasise the difference between her and the interviewer lumps the interviewer together with *you people* (Muslims) who maintain a greater degree of *purdah* compared to *us* (Hindus).

3.8 Conclusion

Addressing the negotiation between the self and the other holds a key role for initiating rapport in qualitative research which is characterised by face-to-face interaction. The process through which data are generated is as crucial as the data itself because the version of truth that we draw from the data is dependent on who collected it and in what way. If the researcher is not sensitive to how the researcher's identity might influence the researched, it will result in a compromise of an extremely essential dimension of qualitative interviewing i.e. rapport building. While reporting the research, it is equally important to inform the reader of what went on between the "self" and the "other" as a sub-text of data generation. Thus, the present research addresses the self and other during the fieldwork and through this chapter, I attempt to inform the reader of this important sub-text of data generation. Being explicit about the researcher's positionality has become even more pertinent in this present research because the subject of investigation is a minority group, which is often a marginalised community due to unequal power sharing between the majority and minority communities.

In order to develop greater rapport, strategies of representation were worked out in great detail before approaching the participants of the research. In order to build rapport in the field I have accentuated the similarity between the self and the other. The comparative nature of the research opened up varied challenges in situating my positionality in the field. I have addressed these challenges through strategies of representation which are conceptualised differently for each research context and research group. Along the range of shifting identifications, I am an insider-of-sorts in India, which is my country of birth. However, I assume an almost-insider status in Bangladesh, of which I am not a national. Hence, my cultural background (language)

has played an important role in familiarising myself in the field rather than my background by virtue of political boundary (nationality). The narration also includes resonance of the differences between the self and other. Being reflexive about these resonances reiterates how important addressing the self-other dynamics is for the research process. Describing these resonances is an expression of accountability on the part of the PI and is a call for more researchers in the social sciences to do the same. This enriches the knowledge on how to address the issues of the self and the other during fieldwork. In the current research, these issues were thought through at the conceptual phase of research which was considered to be crucial in enhancing rapport building during fieldwork.

Chapter 4: What is the effect of religious minority status on fertility at the cross-country level of India and Bangladesh and at the intra-country level of India?

4.1 Introduction

The fertility behaviour of minority groups has attracted the attention of academicians from different disciplines within the social sciences. Such attention over the fertility of minorities stems from the fact that their fertility tends to diverge from that of the majority population. In the ongoing fertility discourse, minority status has been defined by researchers on the basis of race and ethnicity (white, non-white), religion (Catholic, non-Catholic, Jewish, Islam), language (English, non-English) and nationality (Irish, Japanese-American) (Goldscheider and Uhlenberg 1969; Sly 1970; Kennedy 1973; Day 1984; Swicegood et al. 1988; Kohli 1998; Wang and You 2006). In the demographic literature, a group is considered a minority when it constitutes less than 50 per cent (Kennedy 1973; Coward 1980) and a minimum of 8 per cent (Day 1968) of a country's population. In addition to being numerically lesser than the majority group, a minority group is also characterised by coherent subcultures whose members interact with each other and maintain boundary from the rest of the population (Peterson 1964; Jenkins 2004).

The objective of this chapter is to test the effect of religious minority status on fertility at two levels: the cross-country level of India and Bangladesh and at the intra-country

level of India[14]. Muslims constitute a religious minority in India (13.4 percent) and a majority in Bangladesh (87.8 percent), whereas Hindus are a majority in India (80.5 percent) and a minority in Bangladesh (9.3 percent). The initial aim of this chapter is to test the independent effect of religious minority status on fertility in Bangladesh (where Hindus are a minority) and India (where Muslims are a minority) through a cross-country comparison. Second, the independent effect of religious minority status on fertility is tested at the district level of India for both the Hindu and Muslim communities. In order to test the independent effect of the minority hypothesis on fertility the present study compares the two communities, differentially positioned (minority and majority), at cross-country level and intra-country level, which enables the study to gain more valuable insights compared to studying one group in a single context.

The rationale for conducting the first set of analysis was that a cross-country comparative testing of minority status will enable the study to draw conclusions that are applicable to different contexts (Kennedy 1973). The rationale for conducting the second set of analysis was that the fertility level of any group (minority here) is believed to be the result of the local socio-economic and political dynamics (Jeffery and Jeffery 1997; Johnson-Hanks 2006). Further, the current study also conducted a district-level analysis.

The chapter first provides an extensive theoretical background explaining the linkage between religious minority status and fertility. Second, the politics that surround minority fertility globally and specifically in India and Bangladesh are elaborated. Third, a detailed description is given of the data and operationalisation of religious minority status. Finally, the study discusses the results from testing the minority hypothesis and gives possible explanations based on empirical data sources.

[14] Data on district-level religious composition are only available from the Indian census; thus, the analysis was confined to India alone.

4.2 Theories on the role of minority status in fertility discourse

The minority hypothesis argues in favour of an independent effect of minority status on fertility (Goldscheider and Uhlenberg 1969; Sly 1970; Robert and Lee 1974). However, the explanation of the impact of minority status on fertility is diverse. Religious minority groups tend to have high fertility when the group holds a pro-natalistic ideology (van Heek 1956; Day 1968; 1984; Goldscheider and Uhlenberg 1969). Further, the socio-economic disadvantaged state of the minority group tends to have a positive effect on fertility (Kennedy 1973; Bean and Tienda 1988). Feelings of marginality or insecurity could also influence the reproductive behaviour of minorities (Bean and Swicegood 1985). The desire for upward social mobility among educated members of a minority community and the sense of marginality have a negative effect on fertility (Goldscheider and Uhlenberg 1969). Furthermore, Iyer (2002) reasons that in India discrimination against minorities also has consequences for their fertility. Additionally, a native language of the immigrant minority community that is different from that of the receiving country could lower the fertility levels as it involves higher opportunity cost for women to learn a new language (Swicegood et al. 1988; Kohli 1998; Wang and You 2006).

The assimilationist school argues that when the socio-economic and demographic characteristics of majority and minority groups are alike, their fertility tends to converge (Petersen 1961; Lopez and Sabagh 1978; Bean and Swicegood 1985; Dharmalingam and Morgan et al. 2004). The interaction between the socio-economic (occupation, income, education, etc.) and the cultural factors (norms, values, beliefs, etc.) is held as the key in explaining the linkage between religion and fertility by the interactionist school (Chamie 1981).

Several studies, mostly in the American context, have tested the minority hypothesis during the 1960s and the early 1980s (18 articles and some chapters in book) (van Heek 1956; Day 1968; Goldscheider and Uhlenberg 1969; Sly 1970; Kennedy 1973; Roberts and Lee 1974; Ritchey 1975; Lopez and Sabagh 1978; Bean and Marcum

1978; Johnson 1979; Johnson and Nishida 1980; Rindfuss 1980; Gurak 1980; Cooney et al. 1981; Fisher and Marcum 1984; Swicegood et al. 1988; Goodkind 1995; Kohli 1998). However, there are very few studies in the 1990s. The reason for the decline in studies testing the minority hypothesis in recent times is attributed by Goodkind (1995) to the methodological problems in operationalising the independent effect of minority status after controlling for socio-economic characteristics. In the present study, the independent effect of minority status is tested with adequate controls for socio-economic characteristics. Further, empirical testing of the minority hypothesis hardly exists for South Asia, which calls for studies that focus on the fertility of religious minorities in this region. This chapter seeks to fill that gap and test the hypothesis on religious minorities in the South Asian region.

The next section delineates the different dimensions of the political discourse that revolves around the fertility of Muslims and Hindus in the international and the South Asian contexts.

4.3 Politics around fertility

In the recent past, there have been political as well as academic contestations regarding "Muslim fertility" at the international level (Johnson-Hanks 2006). The Muslim community is perceived to be escalating their fertility with an agenda to outnumber the other religious communities (Joshi et al. 2004; Huntington 1996 and Eberstadt 2001; cf. Johnson-Hanks 2006). Contesting this view there are scholars (Jones 2003; Johnson-Hanks 2006) who argue that no one single coherent "Muslim fertility" can be arrived at cross-nationally. Jones (2003) illustrates the variation in Muslim fertility by categorising it into different scenarios. First, countries such as Algeria, Bangladesh, Indonesia, Iran and Turkey exhibit a total fertility rate approaching replacement level. Second, countries such as Azerbaijan, Bahrain, Brunei, Egypt, Jordan, Kyrgyzstan, Morocco, Qatar, and Uzbekistan have a registered fertility below three children per woman. Third, countries such as Afghanistan, Niger and Somalia have registered the highest fertility. Only six out of 15 Muslim majority countries have fertility rates that exceed six children (Johnson-Hanks 2006).

However, countries such as India, Thailand and Australia, Muslims - who are the religious minority there - exhibit higher fertility than the majority religious community (Knodel et al. 1999; Dharmalingam and Morgan 2004). It is evident from these facts that the variations exist within Muslim fertility.

In the South Asian context, specifically in India, Muslims are labelled as pro-natalist (Basu 1997; 2004) due to reasons beyond demography. This trend can be traced back to the introduction of a separate electorate for Hindus and Muslims by the colonial rulers which was later used by the colonisers to create the religious majority and minority discourse in India (Bhagat and Praharaj 2005; Singh 2007). The Hindu-Muslim communal conflict during partition and in the present time has fostered mistrust between the two communities (Hardgrave 1993). This mistrust is exploited by the Hindu right wing that contends that Muslims will outnumber Hindus. This demographic apprehension that Muslim minorities will outnumber Hindu majorities in India is referred to as "Saffron Demography" by Jeffery and Jeffery (2005). However, the apprehension that Muslims will outnumber Hindus is unwarranted since it is not supported by empirical findings (Visaria 1974; Kulkarni 1996; Bhat 2004; cf. Bhagat and Praharaj 2005). Furthermore, the fertility gap between Hindus and Muslims is believed to be narrowing (Bhagat and Praharaj 2005; James and Nair 2005).

In Bangladesh, Hindu fertility is relatively lower than that of Muslims. The census data over the years suggest that there has been a steady decline of Hindu minorities from 13.7 per cent in 1974 to 9.3 per cent in 2001. However, the Bangladesh Bureau of Statistics (BBS) reports that the Hindu growth rate exhibits a "slow trend of increase" (BBS Internet access 2006). The reason for such a "slow trend of increase" is the lower fertility among Hindus. However, growth rate is not a result of fertility alone. Migration plays a role in explaining the "slow trend of increase" observed among Hindus in Bangladesh. Apart from migration during partition in 1947 there has been a steady migration of Hindus from Bangladesh to India to this day (Amin 1997; Dutta 2004).

4.4 Data and Method

This section first elaborates the two sets of data that are used, the micro-level data from the Demographic Health Survey (DHS) of India and Bangladesh and aggregate - level data from the census of India. Secondly, the operationalisation of minority status using the two sets of data at micro and aggregate level is elaborated. In order to ensure comparability of results, a close temporal proximity was maintained in the timeline of the three data sets, namely DHS (India (1998-99), Bangladesh (1999-2000)) and census of India (2001), that were used for analysis.

4.4.1 DHS data

For the cross-country comparison, micro-level and nationally representative data collected by the DHS have been used. The DHS data for both the countries were not collected in the same time period, In Bangladesh[15] the data were collected between November 1999 to March 2000 and in India[16] data were collected between November 1998 to March 1999. There thus is a difference of almost one year. However it is assumed that no exceptional change in the fertility and the co-variates has taken place in India during this period.

4.4.2 Census data

From 1872, the census of India has been collecting information on the size of each religious group in India. Census data on religious group cross-classified by the socio-economic factors were made available for the first time in the history of the Indian census in 2001. The 2001 Census of India provides information on some of the important socio-economic determinants of fertility rates such as place of residence, education and workforce participation for religious groups at state and district level.

[15] The Demographic Health Survey for Bangladesh (BDHS) is a collaborative effort of the National Institute of Population Research and Training, Mitra and Associates, and ORC Macro (USA).

[16] The Demographic Health Survey for India (NFHS) is a collaboration between the International Institute for Population Studies, USAIDS, UNICEF, ORC Macro (USA) and East-West Center Hawaii (USA).

4.5 Operationalisation of religious minority status

In this chapter, religious minority status is operationalised at two levels: first, at cross-country level of India and Bangladesh and second, at the intra-country level (district) of India. DHS data from India (1998-99) and Bangladesh (1999-00) are used for the cross-country comparison and the census of India (2001) for the intra-country comparison.

4.5.1 Cross-country analysis: Interaction between country and religion

At the cross-country level, religious minority status is operationalised as an interaction between religion and country. Consequently, Muslims of India and Hindus of Bangladesh are recoded as a religious minority. Similarly, Hindus of India and Muslims of Bangladesh are recoded as the majority (see Table 4.1 below):

Table 4.1: Country, Religion and Minority status coding of DHS data sets.

Group:		Variable		
		Country	Religion	Minority status
India	Hindus	1	0	0
	Muslims	1	1	1
Bangladesh	Hindus	0	0	1
	Muslims	0	1	0

The data set for the analysis is created through the pooling of data from both the countries for which two new variables, country and minority status, are derived, in which the binary coding for country variable is assigned zero for Bangladesh and unity for India. Since the multivariate analysis is confined to two religious groups, namely Hindus and Muslims, the other religious groups were excluded from the analysis.

4.5.2 Intra-country analysis: Muslim and Hindu concentration index

Hindus and Muslims are not uniformly distributed in the states or union territories of India. Hence, in order to capture the differential distribution of the religious groups, religious minority status is defined within a range between 0 and 100 as the

percentage of the district population who are adherents of Hinduism or Islam. The religious minority status index was calculated as a concentration index of each religious group in the 593 districts and union territories of India.

4.6 The religious differentials in fertility

The current fertility of women, children ever born (CEB), shows that the level of fertility among Hindus in both countries is the same (2.9) whereas Indian Muslims have almost half a child more than their Bangladeshi counterparts (see Table 4.2).

Table 4.2: The mean children ever born and completed family size of Hindu and Muslim women in India- NFHS II (1998-99) and Bangladesh-BDHS (1999-2000)*.

Fertility indicators		Country	
		India	Bangladesh
Mean children ever born (CEB)	**Total**	3.0	3.1
	Hindu	2.9	2.9
	Muslim	3.5	3.1
Completed family size (CFS)			
	Total	4.5	5.7
	Hindu	4.4	4.9
	Muslim	5.8	5.9

* Author's own calculation[17]

The CEB level reveals that the gap between Hindu and Muslim fertility is wider (0.6) in India than in Bangladesh (0.2). However, the gap between majority groups (Hindus in India and Muslims in Bangladesh) is small.

The figures of actual lifetime fertility (CFS) reveals that the difference between Hindus and Muslims is more pronounced than was the case with current fertility (CEB), in both India and Bangladesh. The Bangladeshi Hindus have half a child (CFS) more than their Indian counterparts. However, CFS of Muslims in India and Muslims in Bangladesh seems to converge. In both countries, Muslims have a higher fertility than Hindus. The difference between Hindu and Muslim fertility is more than

[17] For the descriptive analysis of the DHS, sample weights are applied for India and Bangladesh. However, for the regression analysis none of the weights is applied, since both countries employ different sample weights.

one child (5.8-4.4=1.4) in India whereas the difference is of one child (5.9-4.9=1.0) in Bangladesh. The difference in fertility between the two religious groups does not depict the true nature of the relationship that exists between minority status and fertility because the socio-economic factors are not controlled. In order to control such factors multivariate analysis was carried out.

4.7 Cross-country analysis: Religious minority status as interaction between country and religion

This section continues the multivariate analysis with DHS data sets of India and Bangladesh, where minority status is operationalised as an interaction between country and religion. The model is meant to test the following hypothesis: does religious minority status exercise an independent effect on fertility? A binary logistic regression was carried out to test the minority hypothesis. The dependent variable is the (log of the) odds of having three or more children against fewer than three children (recoded into a binary variable) of women in the age group of 40 to 49 years. The dependent variable is categorised into: fewer than three children as a proxy for low fertility and, three and more children as an indicator of higher fertility. The reasoning for such a cut-off point is the two-child norm which is the aspired fertility goal set by the population policies of both countries. Consequently, having three children or more is taken as an indicator of higher fertility.

Apart from religion and country, the controls which were included in the analysis are: a couple's education, wealth index, mass media exposure, rural-urban residence, woman's work participation. Female education has been observed to deter high fertility because higher educated women tend to delay the age of marriage and this eventually results in them having fewer children (Cleland and Jejeebhoy 1996; Basu 1996; Sathar 1996). Education also plays a major role in the transmission of knowledge regarding fertility control, namely information regarding contraception as well as a enhanced accessibility to health institutions (Cleland 2003). In addition to a woman's education, the husband's literacy status is also taken into account as a control in the first two categories of the independent variable labelled as a couple's

education. This is because both a husband and wife's education has important implications for reproductive behaviour (Bankole 1995; Bankole and Singh 1998). In the model a control for wealth status is included as a proxy for economic status of the woman. Female work participation is included in the analysis since it is correlated to the autonomy a woman exercises and is shown to exhibit a negative relationship with fertility (Yadava and Yadava 1999). The exposure of women to the mass media is included in the model because it exhibits negative influence on fertility (Hornik and McAnany 2006). Finally, control for country and religion are also included because both variables are necessary for the construction of the minority variable (see table 4.1). Table 4.3 presents the results of the model. The coefficients are expressed as odds ratios (exp (β)).

The overall explanatory power of this model, as measured by Nagelkerke R^2, is 0.147. The results (see Table 4.3) do not support the minority hypothesis. In order to test it further, additional analyses was carried out by fitting similar models for women in the 30-39 age groups (results not shown here). Also here, no support for the minority hypothesis was found. When the women in the 30-39 age category were further bifurcated into having a high and low educational level (results not shown here), results were largely similar with the earlier models, with the exception that the earlier positive relation between wealth status and fertility did not remain significant for the higher educated women.

Table 4.3: Odds ratios of having 3 or more children ever born among women in the age group of 40-49 (completed family size), India (1998-99) and Bangladesh (1999-2000).

Variables	Odds Ratio (exp (β))
Couple's Education	
Husband & wife illiterate (Ref)	
Husband literate & wife illiterate	1.136
Wife literate-primary	0.827*
Wife middle education complete	0.608**
Wife high school & above	0.226**
Wealth Index	
Lowest quintile(Ref)	
Second quintile	1.256**
Middle quintile	1.383**
Fourth quintile	1.428**
Highest quintile	1.467**
Exposure to mass media	
No exposure(Ref)	
Partial exposure	0.805**
Full exposure	0.631**
Place of residence	
Urban(Ref)	
Rural	1.426**
Respondent's occupation	
Not working(Ref)	
Non-agriculture	0.656**
Agriculture	0.833*
Country	
Bangladesh(Ref)	
India	0.984
Religion	
Hindu(Ref)	
Muslim	1.702**
Majority/Minority status	
Majority(Ref)	
Minority	0.952
Sample Size	19167
Nagelkerke R^2	0.147
Log likelihood Model 0	4.327
Log likelihood Final Model	4.612
Chi-square test overall model (16 df)	404**

Note: (Ref) Reference category. ** p value 0.01, * p value 0.05.

It is evident from the results that with a couple's increasing education, the effect on fertility is negative, meaning the odds of having a large family (3 or more) are lowered substantially. Further, higher exposure to the mass media also reduces the likelihood of high fertility, corroborating existing studies about a negative relationship between mass media exposure and fertility. The results support a negative relationship between women's work participation and fertility; especially, non-agricultural professionals have smaller families compared to women working in the agricultural sector. Women residing in urban centres are also less likely to have three or more children compared to their rural counterparts. Moreover, an increase in wealth heightens the odds of having more children. Cross-tabulation of the wealth index with CEB corroborates the same findings (table not shown). The results also suggest that Muslims, irrespective of country of residence, have more children compared to their Hindu counterparts. To sum up, the cross-country analysis does not support the independent effect of religious minority status on fertility.

4.8. Intra-country analysis: Religious minority status as concentration index

The second set of analysis was conducted in order to account for the local socio-economic characteristics of the minority group in explaining their fertility (Jeffery and Jeffery 1997; Johnson-Hanks 2006). This analysis is confined to India alone because data on religion at the district level is not available for Bangladesh. Religious minority status at the district (sub-regional) level of India is operationalised through the concentration index. The dependent variable, religion-specific total fertility rates, borrowed from Rajan (2005)[18], is estimated through the 'reverse survival method' (Bhat 1996; cf. Rajan 2005). In order to test the minority hypothesis, regression analysis is carried out with total fertility rate as the dependent variable, which is seen as a function of religion, female literacy, female workforce participation, urban

[18] To estimate the TFR, the relationship between child-women ratio (0-6 years child population/women in the age group seven years and above) and crude birth rate (Guilmoto and Rajan 2002) was estimated through a regression analysis at the district level of India. The same regression analysis is applied to estimate the relationship between TFR and child-woman ratio. The crude birth rate for Hindus and Muslims is estimated using an equation: CBR = (0.610) + (0.324*CWR). The equation used for estimating TFR is (-0.894) + (0.0480*CWR).

location and minority status (based on Basu 1996; Sathar 1996; Cleland and Jejeebhoy 1996; Cleland 2003). Given the important role played by female education (Cleland and Jejeebhoy 1996; Cleland 2003) and female work participation, these variables were included as covariates in the analysis. Further, female education and female work participation also increases the level of female autonomy in decision-making, especially in their own reproduction (Basu 1996; Sathar 1996).

The district-level model, based on census data, is estimated separately for Hindus and Muslims and is expressed as follows:

$$TFR(i) = a + b^{(1)}LIT\_F(i) + b^{(2)}WSTAT\_F(i) + b^{(3)}URB(i) + b^{(4)}CONC(i) + \varepsilon(i)$$

where

$TFR(i)$	=	the total fertility rate of Hindus (Muslims) in district i
$a, b^{(1)} .. b^{(4)}$	=	coefficients to be estimated
$LIT\_F(i)$	=	female literacy rate of Hindus (Muslims) in district i
$WSTAT\_F(i)$	=	female work participation rate of Hindus (Muslims) in district i
$URB(i)$	=	urbanisation rate of Hindus (Muslims) in district i
$CONC(i)$	=	concentration index (percentage) of Hindus (Muslims) in district i

All variables are defined in terms of shares, with minimum and maximum values of 0 and 100. The concentration index measures the share of Hindus or Muslims in the total population of the district. Table 4.4 gives summary statistics of each of the variables used in the analysis. From the statistics it is clear that all the covariates are negatively correlated with the fertility level (TFR) of the district. Specifically, the negative impact of female education on TFR is observed to be the most significant variable among the other covariates that were included in the analysis.

Table 4.4: Summary Statistics: Mean, standard deviation, minimum, maximum and bivariate correlation between TFR and covariates, India, 2001.

Covariates	Hindu	Muslim
Female literacy (FL)		
Mean	45.41	45.36
Standard deviation	14.379	16.104
Maximum	87	81
Minimum	15	11
Pearson's R (TFR and FL)	-0.734**	-0.720**
Female work participation (FWP)		
Mean	28.43	17.06
Standard deviation	11.672	9.413
Maximum	57	68
Minimum	4	2
Pearson's R (TFR and FWP)	-0.050	0.166**
Urban residence (UR)		
Mean	25.13	42.06
Standard deviation	21.983	26.315
Maximum	0	0
Minimum	100	100
Pearson's R (TFR and UR)	-0.351**	-0.353**
Concentration index (CI)		
Mean	75.84	11.75
Standard deviation	25.438	15.453
Maximum	100	98
Minimum	1	0
Pearson's R (TFR and CI)	-0.036	0.114**

** Correlation is significant at 0.01

A problem in estimating the preceding equation using classic linear regression is that the units of analysis are spatial areas. It is very likely that the TFR levels of neighbouring districts are more similar than those of distant districts, and this similarity is not completely captured by the four explanatory variables. As a result, the error terms of the model are spatially correlated. Therefore, the study employs a spatial regression model that controls for this spatial dependence (Anselin and Bera 1998; Anselin et al. 2006). Table 4.5 gives the results for Hindus and Muslims in India.

Table 4.5: Results of spatial regression models[§] (spatial error model) of TFR with selected co-variates, India 2001

	Hindus	Muslims
Constant	5.9520 **	6.8510 **
Urban residence	-0.0012	0.0008
Concentration index	-0.0103**	-0.0071*
Female work participation	-0.0051*	-0.0118*
Female literacy	-0.0388**	-0.0591**
Spatial autocorrelation coefficient	0.9014**	0.5939**
Pseudo R^2	0.82	0.66
Number of cases	593	593
Degrees of freedom	4	4

[§] Spatial weights based on Rook's case from Thyssen polygon transformation on x-y coordinates of districts
** Significant at 0.01 level, * significant at 0.05 level

The key variable for the current analysis is the concentration index. It is negative for both religions and highly significant for Hindus, but only marginally significant for Muslims (at the 0.05 level, but not at the 0.01 level). The negative sign of the concentration variable supports the minority hypothesis: the smaller the share of the religious groups in the total population of the district, the higher the TFR. The effect is larger for Hindus than for Muslims. A district with 10 per cent points less Hindus will have, *ceteris paribus*, a TFR which is 0.10 higher. For Muslims the difference in TFR is 0.07. For instance if a district with 90 per cent Hindu population is compared with a district with 10 per cent Hindu population, there is a 0.83 level difference in the TFR among Hindus. Similarly, if a district with 90 percent Muslim population is compared with a district with 10 per cent Muslim population, the difference is 0.56 level in the TFR among Muslims. This indicates that in India the Hindu minority status has a bigger impact on the TFR in comparison to the Muslim minority status. The most important explanatory variable for both religions is female literacy: the higher the female literacy rate the lower the TFR. Muslims are more sensitive to increased literacy levels: a 10 per cent point difference in literacy rates results in a 0.38 level reduction in the TFR among Hindus and 0.59 level reduction in the TFR among Muslims. Female work participation is also significant, but less important: a

10 per cent higher female work participation rate results in a 0.05 level reduction in the TFR among Hindus and 0.11 level reduction in TFR among Muslims. Again, Muslims are more sensitive to increased female work participation. The variable urban population rate is not significant for both religions. In both models the spatial correlation coefficient, controlling for spatially correlated errors, is highly significant.

4.9 Discussion and interpretation of the results

Two measures of minority hypothesis were tested in this chapter, one at the inter-country level (India and Bangladesh), and the other at the intra-country level for India only.

Before comparing the results generated from the inter-country and intra-country analyses, it is worthwhile to asses the comparability of the two models. Therefore, some additional analysis was conducted, firstly to account for the difference in the two measures of fertility being explained (the dependent variables). Secondly, to account for the difference in the specification of the control variables in the two set of analysis. The fertility measure that is explained through the inter-country analyses is CFS (recoded into a binary variable: <=2 children is defined as lower fertility; 3+ children is defined as high fertility) whereas for the intra-country analyses, TFR is the fertility measure being explained. These two measures of fertility are not exactly comparable. CFS is a cohort-based measure and TFR a period measure of fertility. The TFR takes into account the complete distribution of children by parity, whereas the binary recoding of CFS will result in loss of information on the number of children per woman. An alternative is to use CFS in an ordered logit model, taking into account all parities. Additional cross-country analyses were conducted in order to test whether inclusion of this alternative dependent variable results in any change in the outcomes. The new results using ordered logit regression (not shown here) are largely similar with the earlier results (binary logistic).

Secondly, the cross-country model has controlled for two additional variables (wealth index and exposure to the mass media) as compared to the intra-country model. As a

second step, a new model was fitted by dropping these two additional control variables from the cross-country model. The results generated from the new model (without wealth index and mass media exposure) are largely the same as the earlier model (with wealth index and mass media exposure). The new results indicate that there is no misspecification in the inter-country model without the two variables. Hence, the current study assumes that the results of the intra-country analysis would remain the same despite not having controlled for the two variables as the inter-country analysis.

On the basis of empirical analysis, the current study finds support for the minority hypothesis at the intra-country level (district) but not at the inter-country level. To decide which set of results from the two sets of analysis is more credible, an evaluation of pros and cons of each measure is conducted, i.e. the data structure and the operationalisation of minority status.

The micro-level data used at cross-country level furnish extensive information on the research background such as a couple's education, wealth status, exposure to the mass media, place of residence, occupation, country and religion; thus, allowing the study to control for these variables in the model. Further, the results drawn from testing of the minority hypothesis through comparison at cross-country level ensures that the results have the potential for generalisation. However, this measure of minority status drawn from micro-level data does not account for the community's local characteristics such as socio-economic or political standing of the community in the locality, considered crucial for understanding the process through which minority status influences fertility (Jeffery and Jeffery 1997; Johnson-Hanks 2006).

Aggregate-level data used at intra-country level (district level) do not include extensive information at the individual level, such as wealth index or exposure to the mass media as is the case with DHS data set. However, district-level aggregate data enable operationalisation of minority status through the use of a scale covering a range in the minority status. Additionally, this concentration index is also a latent

indicator of the community's local position because it brings into the model the numerical strength of the community. The district-level female education and female work participation also encompass the status of women at the local level. This local character of the community embedded in the control variables is crucial for understanding fertility differentials as has been argued by Johnson-Hanks, (2006: 14): "reproductive rates are social products, are the result of a variety of forms of cultural practices, and deeply embedded in local politics". Due to the nature of the data structure, it was not possible to include extensive controls. However, the variables which are considered most important in explaining fertility levels such as female education and female work participation are included in the model. As rightly pointed out by Goodkind (1995), there is a need to take socio-economic characteristics into account but not so many that it results in mis-specification of the underlying causal processes. Based on the evaluation of the two measures (cross-country and intra-country) the present study argues that the intra-country aggregate level analysis captures the essence of minority status more appropriately than the inter-country micro level analysis. Hence, the results drawn from intra-country testing of the minority hypothesis will be used. In the following, the results drawn from the intra-country analysis will be discussed. The intra-country analysis yielded empirical support for minority hypothesis, namely, the lower the share of a said religious group i.e. Hindu or Muslim, in a given district, the higher their fertility. The results further add that the negative relationship between minority status and fertility is not confined to one religious group, i.e. Muslims, but it is also relatively, and even, stronger for the Hindus.

The following section presents an interpretation of the results from the district-level analysis in India, i.e. irrespective of religion, minority status accentuates fertility. The possible interpretations discussed in the study are not mere conjectures because empirical information from the Sachar committee report (GOI 2006) titled "Social, Economic and Educational Status of the Muslim Community in India" is used to support the arguments found in this chapter. The interpretation given is plausible

because the study has not been able to include certain variables in the model which could have provided definite empirical evidence. For instance, the supply of socio-economic infrastructure, such as health, education and road communication, in a district determines the utilisation of these facilities and eventually has an impact on the fertility level of the district. However, the Census of India does not disclose information on infrastructural distribution at the district-level. Thus, we could not control for infrastructural factor in the model. However, the Census Commission of India provided such socio-economic infrastructure data vis-à-vis the Muslim composition at the village level to the minority commission (GOI 2006) which was later published in the report which examined the socio-economic position of Muslim minorities in India. Though the data are at the village level, the information from the report is considered to be indicative of the larger scenario. The data from the report are used to provide empirical support for the interpretation of results.

4.9.1 Infrastructural disadvantage

The results of the analysis at the Indian district level, confirms the independent effect of religious minority status on fertility. This confirmation of the minority hypothesis means that the smaller the share of the religious groups in the total population of the district, the higher the TFR. Further, the effect of minority status on fertility has been found to be larger for Hindus than for Muslims. The following section provides possible reasoning for high fertility among Muslim religious minority and Hindu religious minority at the district level of India.

The reason for high fertility among Muslim minorities at the district level can be linked to the socio-economic infrastructural disadvantage of the "space" where Muslims reside in India. The Sachar committee report (GOI 2006) attributes the infrastructural disadvantage of Muslims to their typical residential pattern in towns and villages. In the report this settlement pattern is termed as ghetto; however, the current study uses the term concentrated residential pockets (CRP)[19]. The prime reason for Muslims to reside CRPs is the security concerns that Muslims have as a

[19] The term ghetto is negatively loaded.

result of the violent communal conflicts that have taken place between Hindu and Muslim communities (Sarkar 1983; Engineer 2004; GOI 2006). Living in CRPs is also perceived to be a survival mechanism for Muslims because of the reinforced sense of security that arises from living in close proximity (GOI 2006). However, the Muslims residing in such CRPs also endure certain drawbacks; the report contends that the spatial isolation of Muslims from the majority population often results in inadequate supply of infrastructure, such as health, schooling, ration supply, municipal and government offices, to such CRP areas (GOI 2006). The public health facility is one of the main sources of information on fertility control. The lack of such health facilities in the CRPs creates supply-side constraints for the Muslims with regard to their need for family planning services. Additionally, Muslim women in India are also believed to be hesitant in seeking health care in areas beyond their CRP because the CRP is often considered a "safe space" for the Muslim women (GOI 2006). This residential segregation possibly acts as a barrier in effective transmission of family planning knowledge and services to the Muslim women (GOI 2006). The current study reasons that this typical residential pattern of Muslims (in CRPs) in India and the subsequent socio-economic infrastructural disadvantage of this space are likely to have adverse implications for Muslims who wish to plan their family size. However, this disadvantage that is experienced by the Muslim minority in India is not considered by the current study as something inbuilt but as an offshoot of the unequal power entitlement of the Muslims in India due to their minority status.

In the previous section, the infrastructural disadvantage of Muslim space (CRP) was identified as the reason behind higher fertility among Muslims. If this argument is true, then the related question that arises is why do Hindus who happen to be the religious majority at the national level have higher fertility when they constitute a minority at the district level? One possible explanation could be that when the Hindu community is a religious minority in a district; it is likely that Muslims are the religious majority in that district (Muslims being the second-largest religious community in India); and hence, it is possible that Muslim majority districts are also

the most disadvantaged in terms of socio-economic infrastructure. For example, the Sachar committee report (GOI 2006) reveals that the bigger villages (> 2000) of India with higher Muslim inhabitants (40 per cent and above) tend to experience heightened disadvantage in social and physical infrastructural facilities such as educational institutions, medical facilities, postal and telegraph facilities, bus stops, *pucca* (durable) road to the village, and so on. The current study reasons that Hindu minorities who reside in the districts with a higher Muslim concentration also endure the inadequacies of "the disadvantaged Muslim space". This implies that the Hindu minorities residing in those Muslim majority villages experience greater infrastructural disadvantage than the Muslim minorities living in Hindu majority villages. This could possibly explain the reason behind the stronger effect of Hindus minority status on fertility (at 0.01 level) compared to the Muslim minority status (0.05 level). Thus, we argue that high fertility among Hindu and Muslim minorities at the district level of India is two sides of the same coin, i.e. socio-economic infrastructural disadvantage experienced by Muslims, both as a minority living in CRP and also as a majority in a district because they are in any case the religious minority at the national level. This also indicates that religious minority status at the national level has important implications for the supply of socio-economic infrastructure at all levels. Further research should be conducted to quantify the role of this factor on the fertility of the Muslims and Hindus.

4.10 Conclusion

In this chapter, the independent effect of minority status on fertility was tested at the cross-country and intra-country levels. The empirical results support the minority hypothesis at the intra-country (district) level: the smaller the share of the religious groups in the total population of the district, the higher the TFR. The effect is larger for Hindus than for Muslims. Further, the high fertility among Hindu and Muslim minorities at the district level is reasoned by the current study to be two sides of the same coin that is socio-economic infrastructural disadvantage experienced by the Muslims of India. First, the residential pattern which often characterises Muslim settlement (CRP) in India tends to get neglected with regard to the supply of socio-

economic infrastructure. As a result, Muslims suffer from inadequate facilities such as health, education, communication, and so on. The absence of a more developed socio-economic infrastructure in the CRP could possibly explain the reason behind higher fertility among Muslim minorities of India. Second, the districts where Hindus are a minority or in other words, where Muslims are a majority, also tend to experience a heightened level of socio-economic infrastructural disadvantage. Consequently, this absence of socio-economic infrastructure in the Muslim majority district could explain higher fertility among the Hindu minority of the same district.

Goldscheider and Uhlenberg (1969) argue that the minority group experiences lower a level of fertility when it does not uphold pro-natalistic principles. In the current research, the effect of minority status is tested for both Hindu and Muslim communities. These two religions have a different stand on reproductive behaviour. On the one hand, Islamic principles by restricting the use of sterilisation and induced abortion (Shaikh 2003; Keefe 2006) have the potential to accentuate fertility level. On the other hand, there is no such restriction on fertility control in Hinduism (Iyer 2002; Boorah and Iyer 2005). Following the reasoning of Goldscheider and Uhlenberg (1969) Hindu minorities are more likely to have a lower fertility. However, the empirical results suggest that both Hindu and Muslim minority groups tend to have a higher fertility at the district level. This is probably due to the fact that the second condition outlined by Goldscheider and Uhlenberg (1969) which necessitates the minority community to enjoy equal socio-economic status is not met in the Indian context. In India, Muslims suffer from socio-economic disadvantage (GOI 2006). The final condition outlined by Goldscheider and Uhlenberg (1969) is that the desire for acculturation should be present among the minorities in order to effect convergence of fertility levels. Te desire for acculturation among minorities is assumed in the American context which believes in the principle of a "melting pot". However, the Indian society is based on the principle "unity amidst diversity" where every culture nurtures its cultural distinctiveness. Hence, in the Indian context the desire for social acculturation among minority community is not relevant.

Furthermore, the CRP residential pattern of Muslims in India is believed to result from the sense of insecurity arising out of previous communal conflict (GOI 2006). This sense of insecurity is also believed to have implications for the fertility of minorities (Bean and Swicegood 1985). Goldscheider (1999) has observed a similar residential settlement pattern among Arab Muslim minorities in Israel and has linked socio-economic disadvantage of such residential quarters as the reason behind the high fertility of Arab Muslims. The socio-economic disadvantage of minority groups has been observed in other contexts, for instance non-whites in the United States (Ritchey 1975) and Catholics in Northern Ireland (Kennedy 1973), which has been interpreted to be the reason for their relatively higher fertility. The reason for higher fertility among minorities is not considered to be a deliberate attempt on their part to outnumber the majority, rather it is the lack of "rational planning" (Goldscheider and Uhlenberg 1969; Kennedy 1973) on their part because they lack opportunities to climb up the social ladder.

Hence, there is a need to enhance the supply of socio-economic infrastructure in an equitable manner to all the districts of India. The Sachar committee report (GOI 2006) reveals that there is relatively lesser supply of infrastructure in the CRPs, where Muslims reside, and in the districts where Muslims are the majority. There arises the need to address the supply-side constraint, specifically of health services, to the neglected "Muslim space". An equal supply of health services to all will assist the minorities will empower them for planning the family size in an effective manner and also to attain better reproductive health status.

In summary, the independent effect of religious minority status on fertility was tested at two levels i.e. cross-country level of India and Bangladesh and intra-country level of India. The current study has found empirical support for the independent effect of religious minority status on fertility at the intra-country (district) level of India. Minority status in a district accentuates fertility level for both Hindus and Muslims of India. The current study contends that the high fertility of religious minorities in India

is two sides of the same coin, i.e. Muslims are disadvantaged by the lack of in socio-economic infrastructure and this has implication for their fertility.

Chapter 5: Unravelling the "religion effect" in explaining fertility of Hindus and Muslims in India and Bangladesh

5.1 Introduction and background

Various hypotheses have been employed to understand the fertility of religious groups (see section 1.1, chapter 1). One approach, the *minority status* hypothesis (Goldscheider and Uhlenberg 1969; Sly 1970; Kennedy 1973; Robert and Lee 1974) was empirically tested in the earlier chapter. The current chapter examines another hypothesis known as the *particularistic theology* hypothesis (van Heek 1956; Thomas 1983; Heaton and Goodman 1985). The particularistic theology hypothesis argues that religious traditions pronounce rules that govern reproductive behaviour. Religious adherents follow these religious rules of reproduction and that eventually determines their fertility pattern. Hence, the hypothesis assumes that the fertility of the followers of a religion exhibit a certain pattern of regularity. Empirical testing of this hypothesis is primarily conducted for those religions which have pronounced specific rules that have the potential to influence reproductive behaviour. Catholics have received attention in fertility studies in the past. Lately, Muslims have also caught the imagination of demographers seeking to establish the relationship between Islam and reproductive behaviour. The commonality between both religious traditions is that human volition in reproductive behaviour is curtailed. These religious principles perceive control of human fertility as interference in the domain of God. Consequently, they place restrictions on acts of human volition in matters that influence reproduction, for instance, the use of contraception and induced abortion.

Many studies on the fertility of Catholics in America and Europe abound (for America refer to Whelpton et al. 1966; Westoff and Jones 1979) and for Europe, (refer to Coward 1980; Compton et al. 1985; Lesthaeghe and Wilson 1986; McQuillan 1999). The fertility of Muslims has been studied in Africa, Middle East, Europe and South Asia (for Africa, refer to Johnson-Hanks 2006; for the Middle East refer to Chamie 1981; Obermeyer 1994; and for Europe, refer to Westoff and Frejka 2007; for South Asia, refer to Ramesh et al. 1996; Moulasha and Rao 1999; IIPS and ORC Macro 2000; Reddy 2003; Dharmalingam and Morgan 2004; Mishra 2004; Bhat and Zavier 2005; Davis 1951; Nag 1962; Stoeckel 1969; cf. Chaudhury 1981).

The existing studies that have examined the link between religion and fertility in South Asia have primarily used religious group affiliation as a proxy for religion (Dharmalingam and Morgan 2004; Bhat and Zavier 2005), except for Amin et al. (1997) who have used the construct of religiousness to study the linkage. The implicit assumption for using religious group affiliation as a proxy for religion is that mere membership of a religious community is the necessary precondition for influencing reproductive behaviour. The present study considers this assumption to be marred because being born into a certain religious group does not automatically imply compliance to the religious principles to which one owes allegiance. Further, it does not differentiate the extent to which one is committed to a religion's principles. Hence, in order to test the role of religion in explaining fertility there is a need to differentiate the level of religiousness and then test its linkage to fertility outcome. Further, a higher level of religiousness would imply a greater extent of conformity to religious norms dictating reproductive behaviour. For instance, if a religion pronounces restrictions on the use of contraception or induced abortion then the likelihood of abiding to the rules is greater for someone who is more religious. In other words, it is hypothesised that there is a positive relationship between individual level of religiosity and conformity to religious norms of reproduction. However, there is a dearth of empirical analysis that examines the link between the individual level of

religiousness and its impact on fertility in the South Asian context. Further, the existing studies have focussed mainly on religious groups in a single context. In order to fill this void, the present study seeks to explore the role of religiousness on the fertility of Hindus and Muslims in the South Asian context of India and Bangladesh. The unique Hindu-Muslim composition (refer to section 1.2, chapter 1), where the two religious groups are differently positioned in society (belonging to the majority/minority), enables the examination of the same religious group under varied circumstances (Kennedy 1973).

The main research question that the current chapter seeks to answer is: what is the role of religion in explaining the fertility of Hindus and Muslims in India and Bangladesh? Specifically, first, the fertility of Muslims and Hindus is compared in India and Bangladesh. Second, the role of individual religiosity and religious group affiliation (being Hindu or Muslim) is tested in the transition of women between parities in both countries. Third, the reason behind the observed fertility differentials of Hindus and Muslims is explored in India and Bangladesh.

5.2 Data, Method and Sample

The primary data from India was collected from rural Dharwad and urban Bangalore in the state of Karnataka. The primary data from Bangladesh were collected from rural Matlab and urban Dhaka. The rationale for the selection of specific research sites is elaborated in chapter 2 (section 2.7) of this book. Both qualitative and quantitative methods were used for the collection of the primary data. The data were collected sequentially in three phases: quantitative-qualitative-quantitative (section 2.14, chapter 2). These phases of data collection are linked for the purpose of complementarity and development (Greene 2007) of methods (see section 2.13, chapter 2).

Qualitative data for this chapter are drawn from 48 in-depth interviews among Muslim men and women in India and Bangladesh. Out of these 48 in-depth interviews, 32 were conducted among women, 12 among men. Excerpts from 4

illustrative interviews are cited in this chapter. Details regarding recruitment of research participants (section 2.8.1) are elaborated in chapter 2 of this book.

The survey data used in this chapter are drawn from a sample of 800 currently married women (400 each from India and Bangladesh) in the reproductive age group of 18-44 years. In each country, the sample consists of 200 respondents from urban areas (100 Hindus and 100 Muslims) and 200 respondents from rural areas (100 Hindus and 100 Muslims). Details regarding the survey sampling procedure are elaborated in chapter 2 (section 2.14.3).

The fertility measure to be explained in this chapter is the transition of women between parities. Kaplan Meier and Cox Regression are used because they are best suited for such analyses.

5.3 Operationalisation of variables: survey data

For the analysis, the standard of living index and religiosity index were constructed. The following section elaborates the details regarding the construction of these indexes. Further, details of all other variables that are to be included in the analysis are elaborated.

5.3.1 Standard of living index

In the absence of reliable measures of income and expenditure data in developing countries (Hentschel and Lanjouw 1996), the current study has used household ownership of durable consumer goods or assets and housing quality as a proxy for household economic status for the construction of the standard of living index (SLI). In view of the comparative nature of the research, the contextual features of each country and the rural and urban specific features were also taken into account to construct the standard of living index which was constructed separately for both countries.

The household characteristics that were included in the index are: material used for the floor, wall and roof of the house, source of drinking water, type of toilet facility,

ownership of house, ratio of persons per room and type of fuel used for cooking. Additional specifications were attached to the household characteristics such as whether a person has a piped source of drinking water; in addition, whether the source of the water is located within house or in the courtyard which scores higher for that user compared to someone who drinks piped water from a source located elsewhere. These specifications are based on observation during fieldwork. Piped water is rated higher than other sources of drinking water since people with a relatively better standard of living have access to piped water. However, in the research location it was observed that piped water was made available free of charge by the government through public taps or tanks in both rural and urban locations. A higher score was given to those households where the source of piped water is privately owned and is located inside the house or the courtyard.

The other items that were included in the SLI are as follows. The ownership of household assets such as:

- television
- telephone
- electricity
- motor cycle
- refrigerator
- bicycle
- fan
- radio
- sewing machine
- mattress
- bed or cot
- pressure cooker
- chair
- table
- clock/watch
- tractor
- boat

These variables were included in the construction of the standard of living index. Rural Dharwad in India is primarily an agricultural economy, whereas rural Matlab,

Bangladesh, was observed to have other economic activities such as fishing. Therefore, taking into account the contextual economic activities, separate indicators were used for the construction of country-specific standard of living index. For instance, possession of a tractor was included in the construction of the standard of living index of India and the possession of a boat was used for the construction of the standard of living index for Bangladesh.

For the construction of the SLI a total of 23 indicators were used in the current study. The eigen values derived from the principal component analysis in computing the standard of living index was 8.480 for India, or the measure accounts for 37 per cent (8.48/23) of the variation, and similarly 8.420 for Bangladesh, which accounts for 37 per cent (8.42/23) of the variation.

The current study follows Filmer and Pritchett (2001) in the selection of items to be included in the index and the procedure used by them, i.e. principal component analysis, for the construction of the SLI index. Filmer and Pritchett (2001) had used the Demographic Health Survey (DHS) data from India to construct the index and since this study has have included the same asset indicators as the DHS, same procedure has been adopted. The principal component method estimates the appropriate weights to be applied to each component that explains the greatest proportion of total variation between all the variables included (Bollen et al. 2002). By comparing different economic status proxies, Bollen et al. (2002) have found higher empirical support for the principal component method.

5.3.2 Individual religiosity index

In order to overcome the conceptual inadequacy in operationalising religion in the earlier studies conducted in the South Asian context (section 5.1) the current study has constructed a composite indicator of religiosity. The composite indicator of religiosity encompasses multiple dimensions of individual level of religiousness. This composite indicator which is termed as individual religiosity in the current study is similar to Wimberley's (1989) notion of religious identity salience. Religious identity salience

is an important cause for adhering to religious norms (Stark and Glock 1968; Stryker 1980), although the strength of the relationship is dependent on the socially imposed cost and reward for adhering to those norms (Wimberley 1989; McQuillan 1999). In the present chapter, individual religiosity is measured through an index created on the basis of the answers to five questions: importance of religion in childhood, importance of religion in life, importance attached to adhering to religious practices, commitment in adhering to the religious practices and importance of teaching religious values to children. Further, it is important to note that inputs from the qualitative data regarding religiosity were used to formulate the five questions that were included in the survey questionnaire and finally in the individual religiosity index. The selection of items was done with an idea to explore the importance and commitment towards religion in a person's life throughout the life course starting from childhood to the current situation as well as implications for the future generation. The current study defines the index as individual religiosity and by no means suggests that this index is the only way to conceptualise religious belief. The response to each question is elicited on a three-point scale (Chaaya et al. 2007) of low, average and high, which were given the values of 1, 2 and 3. The index was constructed through the technique of principal component analysis. The eigen values derived from the principal component analysis in computing the religiosity index are: 2.537 for India and 2.712 for Bangladesh; they explain 51 (2.537/5) and 54 (2.712/5) per cent of the total variation among the indicator variables.

5.3.3 Other variables

The dependent variable used in the analysis of fertility in the current chapter is the parity progression in childbearing, i.e. the rate at which a woman has the next child. It is operationalised through the duration between the first and the second child and then second to the third child. [20] Since, the dependent variable is duration between parities

[20] Measurement of fertility based on cross-sectional data is often carried out through Children Ever Born (CEB), but it does not account for the stage in a woman's reproductive career. Age of the woman can be taken into account but it does not ensure one to one correlation with the current stage of the fertility career, and timing differences obscure the true differences in fertility between women. Hence,

(1-2; 2-3). The duration between marriage and the first child was not taken into account because couples in South Asia are socially expected to have their first child soon after marriage (Pande 2006). Hence, the focus was directed on the transitions to parity two and three because people start to plan the timing of childbearing after their first child. The independent variables that are controlled in the analysis are religious group affiliation, i.e. being Hindu or Muslim, individual religiosity index, education (Cleland and Jejeebhoy 1996; Basu 1996; Sathar 1996), standard of living (Filmer and Pritchett 2001), location (Eberstadt 1980), exposure to mass media (Hornik and McAnany 2006), age and work status of the woman (Yadava and Yadava 1999).

5.4 Transitions to higher order parities

The survival curves in figures 5.1 and 5.2 using Kaplan Meier analysis indicate that Hindus and Muslims in India differ in their transition between the first and the second child. More specifically, figure 5.1 shows that the transition from parity one to two is sooner among Muslims, compared to Hindus. For example, the Muslims exhibit relatively less spacing between parity 1 to 2 by maintaining a median duration of 25 months whereas Hindus maintain a gap of 32 months between the first and the second child. The Hindu-Muslim difference in spacing between parity 1 and 2 is highly significant (Mantel-Cox test: 0.01). Taking this observation further, Figure 5.2 shows that the Hindu-Muslim difference in spacing widens in the higher parities i.e. parity 2 to 3. This suggests that in India, Muslims seem to have the third child relatively faster than Hindus. For example, Muslims on an average maintain a gap of 36 months (median duration) between their second and third child whereas Hindus maintain a gap of 51 months. The Hindu-Muslim difference in spacing between parity 2 and 3 is also highly significant (Mantel-Cox test: 0.01).

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by focusing on parity and to investigate the transition from one parity to another, the current study is able to eliminate the confounding effect of the stage in family formation.

Survival curves showing duration between 1-2 and 2-3 child among Hindus-Muslims in India, Bangladesh

Figure 5.1

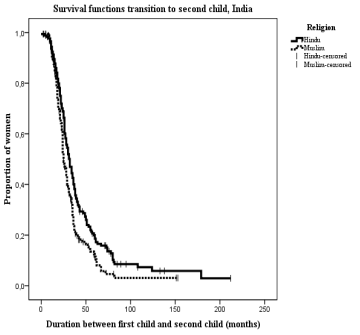


Figure 5.2

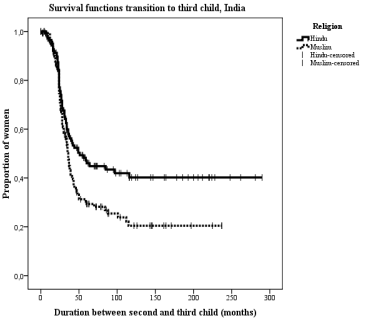


Figure 5.3

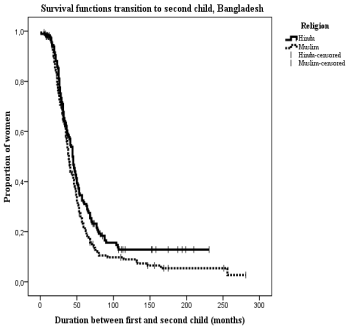


Figure 5.4

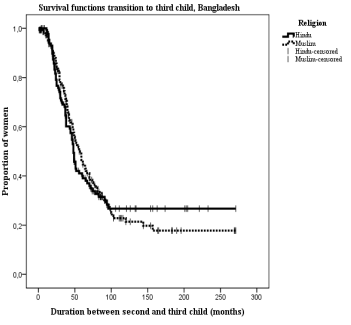
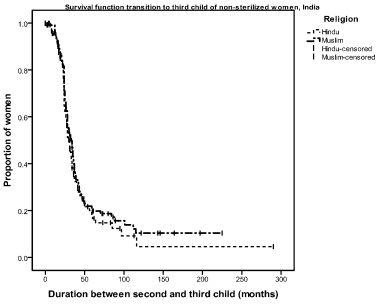


Figure 5.5



From the survival curves depicted in Figure 5.3, Muslims have their second child sooner than the Hindus in Bangladesh. This is similar to the Indian pattern. For example, in Bangladesh, the Muslims have their second child within a span of 39 months (median duration) after the birth of their first child; whereas Hindus have their second child in 44 months after the birth of the first child. The Hindu-Muslim difference in spacing between parity 1 and 2 is stronger in India (Mantel-Cox test: 0.01) compared to Bangladesh (Mantel-Cox test: 0.05).

In Bangladesh, the Hindu-Muslim difference in transition is less pronounced between parity 2 and 3. Muslims registered a median duration of 56 months whereas Hindus registered a median duration of 48 months. This means that Muslims on an average maintain a longer spacing between their second and third child than Hindus in Bangladesh. However, the difference between Hindus and Muslims from parity 2 to 3 is not statistically significant (Mantel-Cox test) in Bangladesh.

From the descriptive results it can be concluded that Muslims in India and Bangladesh have their second child faster than Hindus in their respective countries. Further, the Indian Muslims have their third child sooner than Hindus; however, the Bangladeshi Hindus and the Muslims do not substantially differ in their transition from parity 2 to 3.

Considering the fact that in India women often get sterilised after attainment of their desired family size, an additional Kaplan Meier (figure 5.5) was plotted with non-sterilised women, in order to ascertain whether the Hindu-Muslim difference in spacing still continues in their transition to the third parity[21]. A Kaplan Meier was plotted for women in the second parity because women in India hardly get sterilised after their first child. Figure 5.5 suggests that the former difference between Hindus and Muslims no longer remained statistically significant. For example, Muslims on an

[21] Contraceptive practices play a crucial role in determining spacing between parities. Hence, it is worthwhile to mention that India and Bangladesh differ with regard to the method of contraception that is used in each country. Sterilisation is the main method of contraception in India whereas temporary methods are the most common method of contraception in Bangladesh.

average (median duration) maintain a gap of 37 months between their second and the third child whereas Hindus maintain a gap of 36 months. This indicates that in India the Hindu-Muslim difference in spacing behaviour (parity 2 to 3) might be due to the differential use of sterilisation method by the two groups and not due to difference in timing of birth.

5.5 Children Ever Born

The differences in transition to higher parities between Hindus and Muslims depicted through the survival curves raises one further question: whether this Hindu-Muslim difference in the transition between parities is also reflected in the size of their completed family. The sample size of the current study is rather small, and hence the data do not allow an investigation of the fertility differentials through the indicator completed family size i.e. fertility of women in the 40-49 age groups. Hence, the next best option, i.e. the mean number of CEB among women beyond age 35, was carried out. The figures in Table 5.1 suggest that in India, Muslims on an average have one child more than Hindus, whereas in Bangladesh the difference is less than half. The F-ratio generated through analysis of variance suggests that religion has a significant effect on CEB. However, there is no significant country-level difference in CEB. Additionally, the effect of religion on children ever born is significantly different (0.10 level) for India and Bangladesh. Support is found for the interaction effect of country and religion-minority hypothesis in the current analysis. This indicates that religion has a differential effect on fertility in India and Bangladesh. However, support for the interaction effect (minority hypothesis) was not found in the earlier DHS analysis at the cross-country level (chapter 4).

Table 5.1: Mean children ever born (CEB) to women in the 35+ age group and analysis of variance (ANOVA) of CEB with religion, country and the interaction between religion and country.

Country	Religion	Mean children ever born
India	Hindu	3.0
	Muslim	4.1
Bangladesh	Hindu	3.2
	Muslim	3.5
Analysis of variance	**F value**	**Significance**
Religion (R)	28.7	0.004
Country (C)	1.2	0.269
Interaction R*C	2.9	0.086
Adjusted R squared	0.061	

5.6 Explaining transition to higher parities

The above analysis of variance does not control for socio-economic factors which play an important role in determining fertility outcomes. Hence, there is a need to control for socio-economic factors. Further, the study seeks to test the role of religion (individual religiosity; religious group affiliation) in explaining the transition between parities.

Table 5.2: Description of control variables and summary statistics: mean, standard deviation, minimum, maximum, India and Bangladesh

		Bangladesh				India			
Variables	**Variable Coding**	**Mean**	**Standard Deviation**	**Minimum**	**Maximum**	**Mean**	**Standard Deviation**	**Minimum**	**Maximum**
Individual religiosity	Continuous	0	1	-4.568	1.157	0	1	-1.667	1.645
Religion	0=Hindu (Ref) 1=Muslim	0.5	0.5	0	1	0.5	0.5	0	1
Education (completed years of schooling)	Continuous	6.3	4.7	0	16	7.7	3.2	0	17
Standard of living	Continuous	0	1	-1.675	1.811	0	1	-5.940	1.394
Location	0=rural (ref) 1= urban	0.5	0.5	0	1	0.5	0.5	0	1
Exposure to mass media	1= no exposure (ref) 2=partial 3=full	1.3	0.9	1	3	1.9	0.9	1	3
Age	Continuous	30.9	7.1	18	44	28.17	7.0	18	43
Working status	0=Yes (ref) 1=No	0.5	0.5	0	1	0.5	0.5	0	1
Sample		400				400			

In order to examine the underlying factors that influence the timing of the second and third births, Cox regression analysis was carried out across parities, separately for India and Bangladesh. Table 5.2 provides a detailed description (codes) of control variables and a summary of the statistics.

First, the following hypothesis is tested: what is the effect of individual religiosity and religious group affiliation on the transition between parities (1 to 2 and 2 to 3) after controlling for background characteristics in both the countries? The size of the relative risk is expressed through the exponential β (beta) in Table 5.3. The results suggest that there is no statistically significant relationship between individual religiosity and transition between first and second parity. Further, the results reveal that in India after controlling for background factors, the religious group affiliation is significant in explaining the transition between first and the second child. A Muslim mother has a relatively higher risk of having the second child earlier than a Hindu mother. A higher educated mother is at lower risk of having her second child sooner compared to a lower educated mother. Older women are at greater risk of having the second child sooner than their younger counterparts.

This raises the question of whether the difference in the spacing behaviour of Hindus and Muslims in India is restricted to the lower parities (from first to second child) or whether the difference is carried forward to the next higher parity (from second to third child). The results corroborate earlier findings of lower parities (parity 1 to 2) that individual religiosity does not influence the transition from the second to the third child. Further, Muslim women are more likely to have their third child earlier than Hindu women. However, compared to the results from lower parities, the difference is that the richer women delay having a third child whereas in the lower parities (parity 1-2), higher educated mothers delayed having a second child.

In summary, the results indicate that a Muslim mother faces a substantially higher risk of having the second and third child earlier than a Hindu mother. However, individual

religiosity is not found to influence the transition between parities for both Hindus and Muslims of India.

The next question the current research seeks to answer is: does the Hindu and Muslim difference in transition between parities that is observed in India persist in Bangladesh?

The results from table 5.3 suggest that in Bangladesh individual religiosity does not explain transition of women in their lower parities (parity 1-2). However, religious group affiliation is statistically significant in explaining transition in lower parities (parity 1-2). Specifically, a Muslim mother of one child has a greater risk of having her second child earlier than a Hindu mother. Education plays a significant role in explaining the transition between parities (parity 1-2). The results indicate that women living in an urban set-up have children later compared to women living in rural set-up.

Similar to the previous findings about lower parities, in Bangladesh, the individual religiosity does not explain the transition from parity two to three. Further, there is convergence of spacing behaviour observed among Hindus and Muslims in their transition to the higher parity (parity 2-3). Hence, being Hindu or Muslim does not play any significant role in explaining the transition of women between parity two to three. Higher educated women are at a lower risk of having the next child sooner than their less educated counterparts.

Table 5.3: Cox regression of the effects of socio-demographic characteristics on first birth timing to the second birth timing, and second birth timing to third birth timing: relative risks, India and Bangladesh

Variables	India	Bangladesh	India	Bangladesh
	Parity 1-2	Parity 1-2	Parity 2-3	Parity 2-3
	exp (β)	exp (β)	exp (β)	exp (β)
Individual Religiosity Index	1.003	1.062	1.093	0.957
Religion (Muslim vs. Hindu)	1.371*	1.299*	1.417*	1.260
Education	0.963*	0.948**	0.995	0.899**
Standard of living	1.071	1.224	0.669*	0.920
Location	0.850	0.518*	0.771	0.358*
Exposure to mass media	1.032	0.960	1.159	0.939
Partial exposure	1.059	0.948	0.976	1.236
Full exposure	0.914	0.854	0.892	0.894
Age	1.020*	1.015	1.041**	1.022
Working status	1.150	1.362	1.252	1.079
Events	288	285	163	177
Overall Chi Square Test of Model	20.440**	47.186**	50.794**	79.504**
Degrees of freedom	10	10	10	10
-2 log likelihood	2843.070	2809.761	1598.248	1656.787

* Significant at 0.05
** Significant at 0.01

In summary, the testing of the *particularistic theology* hypothesis has not yielded conclusive results. First, the relationship between individual religiosity and transition between parities could not be established in both the countries. Second, despite being co-religionists Muslims have different fertility trajectories in the two countries. However, what remains unexplained is the reason behind the higher fertility trajectory of Muslims compared to Hindus in India whereas the Muslims of Bangladesh seem to follow a lower fertility trajectory compared to Hindus. In order to find an answer to this intriguing question as to why Muslims of India follow a high fertility trajectory, an in-depth exploration of fertility among Muslims in India and Bangladesh is undertaken in the following section.

5.7 In-depth exploration of Muslim fertility in India and Bangladesh

In order to unravel *why* the Muslims in India exhibit less spacing and higher fertility, it will be worthwhile to compare the reproductive behaviour of Muslims not just in India but also in Bangladesh. By comparing the same religious group in two contexts

the underlying processes that have led the two groups to exhibit different fertility trajectories can be unravelled. The current chapter, first, examines whether Muslims in India desire a bigger family size compared to Muslims in Bangladesh. Second, the chapter examines whether the population policy of India envisaged a bigger family size in comparison to that of Bangladesh.

5.7.1 Interpreting the process behind Muslim fertility outcome: A comparison

In order to uncover the reasons behind the different trajectory of Muslim fertility in India and Bangladesh, Muslim men and women were interviewed regarding their views about family size. The vision of the population policy planners regarding fertility levels of the respective countries was also examined. This comparison of vision regarding family size at macro and micro level is undertaken in order to determine whether it is the individual perception of family size or the government's vision of fertility level that holds the key to high fertility among Muslims in India. A combination of insights from the survey and qualitative data are used for this purpose.

Comparing vision of family size at individual and policy level

Muslim women from both countries were asked about their desire for an additional child, given their fertility status (surviving). Table 5.4 illustrates that the desire for an additional child is higher among the Indian Muslim women who have one surviving child. The difference in desire for an additional child between Indian and Bangladeshi Muslim mothers of one surviving child is significant at 0.01 level (z-test). Further, the difference in desire for an additional child between Indian and Bangladeshi mothers of two surviving children, is significant at 0.05 level (z- test). As the number of surviving children increases, the desire for an additional child does not remain significant for the Muslims in India as well as Bangladesh. In the given context, it is important to add that women who experience child loss are also the ones who are more likely to express their desire for an additional child as a means to compensate their loss. The data from the current study confirms this because the Indian Muslims (mother of one surviving child) have experienced greater child loss (20 percent) compared to Bangladeshi Muslim mothers of one surviving child (9.7 percent).

Hence, the study interprets the Indian Muslims woman's greater desire for an additional child to result from the greater experience of child loss.

Table 5.4: Percentage of Muslim women desiring an additional child by parity (%)

	Desire for an additional child	
Surviving children	**Indian Muslim**	**Bangladeshi Muslim**
1	97.4	81.1
2	62.2	31.1
3	18.2	9.1
N	62	54

Muslim men and women were asked through in-depth interviews for the reason behind their stated preference of family size. The text that follows are excerpts from the in-depth interviews.

[Q: In your view, how many boys and girls should a family have?
A: Two sons, two daughters or one son and one daughter. A big family does not look good. If you have more children then it creates trouble. We should have children according to our capacity. Only those that we can feed should be born. It is not right to just bear children and put them into the world. Later they will say, gave birth and left silently (without taking care). Have no ability to feed but gave birth!]
(Participant 1: Female, 25 years old, urban Bangalore, India, 5 years of education)

[Q: How many children do you think a family should have?
A: I think having two children is enough; it may be a boy or a girl; having two children is enough.
Q: Why?
A: If we have more children then it will be a problem for us to take care of them in a proper manner. It will be difficult for us to educate those children. That is why it is not advisable to have more children.]
(Participant 2: Male, 26 years old, rural Dharwad, India, 14 years of education)

[Q: According to you, how many children should one have in a family?
A: I feel having one child is good.
Q: Why?

A: If it is one child then we can give it proper attention and make it a good human being.

Q: Boy or girl?

A: Whichever, is ok, either boy or girl, if it is a good human being that is enough.]

(Participant 3: Female, 26 years old, urban Dhaka, Bangladesh, MA degree)

[Q: How many children should one have in a family?

A: At the most two children are enough.

Q: Why?

A: Our country is a country of scarcity. Everything is expensive. Two children can be given everything, proper upbringing including education.]

(Participant 4: Male, 43 years old, rural Matlab, Bangladesh, 8 years of education)

Irrespective of the gender, education and location of the participants, there is a unanimous preference for a small family among Muslim men and women both in India as well as Bangladesh,. As stated by the participants, the reason for a favourable attitude towards a small family is primarily because having more children is not feasible due to economic constraints. The need to give a better quality of life to the child was stressed upon by most of the participants. The population policies of both countries will be examined in order to understand the stand of policy planners regarding desired fertility levels.

The population policies of India and Bangladesh have set out demographic goals for their respective populations. Both the policies are directed towards controlling fertility to a replacement level. The goal set by the National Population Policy of India (GOI 2000) is to attain a net replacement level of fertility, i.e. 2.1 children per woman, [22] by 2010. The goal set by the Bangladesh population policy (2004) is to attain a net reproduction rate equal to one[23] by the year 2010.

[22] A woman replaces herself and her husband in the population.

[23] Each generation of mothers have exactly enough daughters to replace them in the population

In summary, the governments of both countries through their set demographic goals reflect their preference for a small family norm. Reiterating the government's stand, the Muslim women and men from both countries also seem to prefer fewer children. After gathering the vision of individuals at the micro level and policy planner at the macro level what remains unexplained is why Indian Muslims are not able to realise their fertility aspirations like the Muslims of Bangladesh.

In order to answer this question, the current study examines whether there is any differences that can be distinguished between Muslims of India and Bangladesh with regard to the proximate determinants of fertility.

5.7.2 Proximate determinants of fertility: A comparison

Any attempt to unravel the reasons behind differential fertility of two groups is incomplete without comparing the differences that exists across the proximate determinants of fertility i.e. age at marriage, post-partum amenorrhea, induced abortion and contraception (Bongaarts and Potter 1983).

Table 5.5: Mean age at marriage and post-partum amenorrhea among Muslims in India and Bangladesh (2007-2008)

	India Muslim	Bangladesh Muslim	India N	Bangladesh N
Mean age at marriage	16.3	16.7	200	200
Median duration of post-partum amenorrhoea*	5.8 months	6.4 months	138	122

*Mean number of months of post-partum amenorrhea after births in the five years preceding the survey

The figures in Table 5.5 indicate that Muslim girls in India marry 4 months earlier than their Bangladeshi counterpart. A z-test reveals that the difference in the mean age at which Indian and Bangladeshi girls get married is not statistically significant. After giving birth the Muslim women in India resume menstruation half a month earlier than the Muslim women in Bangladesh. A z-test reveals that the Hindu-Muslim difference in post-partum amenorrhea is not statistically significant. These figures indicate that there is no marked difference between the Muslims of India and Bangladesh with regard to age at marriage and post-partum amenorrhea. The figures

of induced abortion are not included here, firstly because it is a rare event (less frequent) and sample of this study is too small to calculate it. Secondly, sex-selective abortion is declared illegal by Indian law. Induced abortion is not legal in Bangladesh unless there is a threat to the mother's life. Further, due to religious prohibition there is social stigma attached to the practice of induced abortion in the South Asian context. Hence, respondents hesitate to disclose such information due to the sensitivity of the topic. In the following section, the differential in the use of contraceptive methods among Muslims of India and Bangladesh is discussed.

Table 5.6: Percentage of Muslim women using contraception (ever use) by method type in India and Bangladesh (2007-2008)

Ever use	India Muslim	Bangladesh Muslim	Method	India Muslim	Bangladesh Muslim
Yes	61.5	85.5	**Temporary**	59.5	96.0
No	38.5	14.5	**Sterilisation**	40.5	4.0

* Currently married women in the age group of 18-44 years

Acceptance of contraceptives by two religious groups

Figures on ever use of contraception (see table 5.6) reveal that contraceptive use among Muslims in India is significantly lower than among Muslims in Bangladesh (24 per cent). A z-test confirms that the difference in contraceptive use among both groups is highly significant (0.01 level). This indicates that out of three proximate determinants of fertility, that are examined here, Muslims in India and Bangladesh differ significantly with regard to the use of contraception. Since Muslims of India and Bangladesh show a marked difference in the use of contraception there is a need to undertake an in-depth exploration that examines the dynamics of contraceptive use. Table 5.6 clearly indicates that Muslims from both countries show preference for temporary methods of contraception. The Muslims of Bangladesh have shown absolute preference for temporary methods (96 per cent). Muslims in India have also shown relatively higher preference for temporary methods (60 per cent) compared to sterilisation (41 per cent). A further z-test confirms that Muslims of India and

Bangladesh differ significantly with regard to the use of temporary and terminal methods (0.01 level).

Table 5.7: Odds ratio of using sterilisation method as opposed to other methods of contraception among currently married women in the age group of 18-44 years, India.

Variables	Odds Ratio (exp (β))
Religion	
Hindu (Ref)	
Muslim	0.172**
Education (continuous)	0.837
Standard of living index (continuous)	0.587
Individual religiosity index (continuous)	0.929
Location	
Rural (Ref)	
Urban	0.464
Exposure to mass media	
No exposure (Ref)	
Partial exposure	0.800
Full exposure	1.566
Female work participation	
Not working (Ref)	
Working	1.344
Children ever born (continuous)	4.201**
Age (continuous)	1.084*
Sample size	253
Nagelkerke R^2	0.572

Note: (Ref) Reference category. ** p value 0.01, *p value 0.05

Since a significant proportion of Muslim women do not use temporary methods of contraception in the Indian context, it is important to find out the extent to which the Muslims in India use sterilisation beyond two children? [24] In order to examine this, a logistic regression analysis was carried out with a dependent variable named steri (steri=1: if the woman is sterilised; steri=0: if woman is using other methods). The other variables included in the model are: religious affiliation, individual religiosity, education, standard of living, location, exposure to mass media, age and working status.

[24] The Indian government's goal of attaining replacement level of fertility; i.e. 2.1

The analysis clearly reveals that the odds of using sterilisation as a method of contraception is substantially lower among Muslims (0.01 level) in India as opposed to Hindus in India. The odds of using sterilisation get higher with increasing age of women and bigger family size. Hence, the higher fertility of Muslim in India can be attributed to the lower use of contraception (sterilisation method) among them. This result still does not reveal why Muslims in India despite being less inclined to use the sterilisation method still use it. Further, why do Muslims in Bangladesh absolutely refrain from using the sterilisation method? Finally, despite being co-religionists, why do Muslims in India and Bangladesh exhibit substantial differences in their use of contraception?

5.8 Conclusion

The present chapter tested the *particularistic theology* hypothesis among the Hindus and Muslims in India and Bangladesh. The role of religion (*particularistic theology*) was operationalised as individual religiosity and religious group affiliation (Hindu or Muslim). Those who are more religious were assumed to abide by religious rules of reproduction. This assumption was not supported by empirical findings because individual religiosity did not explain the transition between parities (1-2 and 2-3) in India as well as Bangladesh. Further, despite being co-religionists Muslims follow different fertility trajectories in India and Bangladesh. In summary, the testing of the two measures of religion (*particularistic theology* hypothesis) with the fertility outcome has not yielded conclusive results. Thus, the *particularistic theology* hypothesis is rejected because both the measures of religion failed to garner empirical support for its independent linkage with fertility behaviour.

However, being a Muslim (religious group affiliation) in India has resulted in a higher fertility trajectory. Hence, it remains unexplained what being a Muslim in India entails so that it results in a higher fertility trajectory compared to Hindus in India. Further, the Muslims in Bangladesh seem to follow a fertility trajectory which has converged with that of the Hindus. Being a Muslim in India has consistently remained the significant factor in explaining shorter spacing between births and high fertility.

Hence, an in-depth exploration of differential Muslim fertility was carried out by solely confining the study to the Muslim case in India and Bangladesh

Insights from the survey and in-depth interviews suggest that a small family is favoured by Muslims in India as well as in Bangladesh. The wish for a small family is attributed to economic constraints. Further the policy planners also envisage a small family norm in the respective countries. Why Indian Muslims do not realise their desired fertility norm needs further exploration. In order to unravel this puzzle the proximate determinants of Muslims in both countries were compared. Out the three most important proximate determinants of fertility examined in this study, the Muslims of India and Bangladesh differ considerably in the use of contraception. Specifically, it was observed that the Muslims of both countries differ in their use of contraceptive methods. The common factor among Muslims of both countries is that there is a clear preference for temporary methods over the terminal method of contraception. This preference for temporary methods of contraception is in par with the Islamic rules that forbids the use of sterilisation. However, Muslims of India seem to use both temporary and sterilisation methods. A further explanatory analysis reveals that Muslims are less inclined to resort to sterilisation as compared to Hindus in India. Then what remains unanswered is why Muslims in India use sterilisation when they do not favour its use? This current chapter argues that the use of sterilisation by the Muslims of India -despite the fact that they are less inclined to use it- is the missing link to the puzzle of the higher fertility trajectory of Muslims in India. The following chapter undertakes an in-depth examination of the reasons behind the higher fertility trajectory of Muslims in India and their higher use of sterilisation.

Chapter 6: Untangling the notion of "high Muslim fertility" in a comparative setting of India and Bangladesh

6.1 Introduction

Some religions maintain a discreet stand on reproductive matters while others have elaborated on the methods of fertility control to be used and avoided. For instance, Hinduism does not pronounce any clear stand on fertility control (McQuillan 2004) probably because Hinduism considers reproductive events such as menstruation and delivery as ritually polluting (Iyer 2002; Borooah and Iyer 2005). Islamic injunctions are believed to approve fertility control (Obermeyer 1992); nevertheless, it is opposed to the use of sterilisation and induced abortion (Shaikh 2003; Keefe 2006). However, the interpretations of the Islamic injunctions vary across the schools of Islamic law, religious leaders and political leaders (Obermeyer 1992). Religious leaders play a crucial role in the interpretation of religion and are considered as "opinion makers" (Ali and Ushijima 2005). They could play a positive role in educating community members in reproductive health matters (Iyer 2002; Ali and Ushijima 2005). For example, in Jordan, the religious leaders played a positive role in reproductive matters (Underwood 2000). Further, the political leaders along with religious leaders are also shown to influence the family planning programmes (Aghajanian 1995; Amin 1997; Hoodfar and Assadpour 2000).

Some researchers argue that an analysis of theological injunction is not the right perspective to understand the linkage between religion and fertility control; rather the

focus should be directed on the broader dimensions of social structure such as the family and gender norms (Goldsheider and Mosher 1991; Goldsheider 1999). Goldscheider (1999: 311) further elaborates that "the key to clarifying how religious values influence reproductive patterns is located in the community - family level, where individuals and values are anchored, where relationships between the generations and between men and women are under social control, and where economic development and political processes are translated into networks and opportunities". Further, female autonomy is said to exhibit an inverse relation with fertility (Jejeebhoy 1995) but the linkage between female autonomy and Islam is contested (Obermeyer 1992; Jejeebhoy and Sathar 2001; Morgan et al. 2002; Amin and Lloyds 2002).

McQuillan (2004: 49-50) suggests three conditions under which a religion influences demographic behaviour. First, the religion should pronounce rules that influence reproductive behaviour. Second, the religion should be able to translate its teachings to its followers and ensure conformity. Third, there exists a strong sense of attachment among the followers as members of a community. The third condition brings to prominence the role that group dynamics can play in explaining demographic behaviour. This group dynamics is also influenced by the nature of relationship with groups other than one's own group. For instance, McQuillan (2004) reasons that the sense of solidarity or attachment with one's in-group gets strengthened when the relationship with the out-group is marked by conflict and competition. This sense of conflict and competition between groups can also translate into residential segregation, as observed by Goldscheider, (1999), among Arab Muslim minorities in Israel. The Muslim minorities of India also tend to live in residentially segregated quarters (see chapter 4) and this is perceived to be an offshoot of the security concerns arising out of the past communal conflicts between the Hindus and Muslims (Sarkar 1983; Engineer 2004; GOI 2006). Additionally, these residential settlements where members of a religious community live close to each other is believed to result in greater conformity to religious values (McQuillan 2004) because it induces a

heightened level of social control over its members. Further, Goldscheider (1999) observes that there is limited economic and infrastructural development in the segregated residential quarters where the Arab Muslims reside in Israel. Goldscheider (1999) further reasons that the high fertility of Arab Muslims in Israel can be explained through the socio-economic disadvantage of the residential quarters inhabited by the Arab Muslims of Israel. Similarly, the Sachar committee report (GOI 2006) points out that the Muslim minorities in India also experience socio-economic disadvantage. Further, the socio-economic standing of a religious group is also considered to be an important determinant of their fertility (Riccio 1979; Kollehon 1994; Iyer 2002). The present research makes a similar link in chapter 4; the socio-economic infrastructural disadvantage of the concentrated residential pocket (CRP) is reasoned to be a possible explanation for higher fertility levels among the Muslim minorities residing in India.

Linked to the findings in chapter 5 of this book - that the Muslims in India have followed a high fertility trajectory - the current chapter explores in detail the reasons behind the differential fertility among Muslims in India compared to Muslims of Bangladesh. The main research question that the current chapter seeks to answer is: what can be learned from a comparison of Muslims fertility in India with that of Bangladesh?

6.2 Data and method

Qualitative data for this chapter are drawn from 48 in-depth interviews among Muslim participants in India and Bangladesh. Out of these 48 in-depth interviews, 32 were conducted among women, 12 among men, 4 among religious leaders. Two in-depth interviews with nurses are also included. Excerpts from 8 illustrative interviews are cited in this chapter. The criteria to recruit the female participants of the present research were their age, religious background, fertility status and education. The age criteria for recruiting participants were: 18-44 years in the case of women and 18-50 years in the case of men. The educational background of the research participants was taken into consideration because education plays an important role in determining the

course of reproductive behaviour. As the research was on reproductive decision making, recruitment was restricted to only those men and women who had at least one surviving child. The baseline data collected through complete coverage were used to recruit participants for the in-depth interviews. Details regarding recruitment of research participants (section 2.8.1) is elaborated in chapter 2 of this book.

The survey data used in this chapter is drawn from a sample of 800 currently married women (400 each from India and Bangladesh) in the reproductive age group of 18-44 years. In each country, the sample consists of 200 respondents from urban areas (100 Hindus and 100 Muslims) and 200 respondents from rural area (100 Hindus and 100 Muslims). Details regarding the survey sampling procedure are elaborated in chapter 2 (section 2.14.3).

6.3 Unravelling the story behind higher Muslim fertility in India

The answer to the research question raised in this chapter is multi-faceted and is deeply embedded in the institutional, socio-cultural and political contexts of both countries. The comparison of the contexts of the two countries reveals that Muslims in India experience greater constraints than Muslims in Bangladesh in realising their desired family size. The constraints faced by Muslims in India in realising their desired family size can broadly be categorised into: characteristics of the family planning programmes (different methods propagated), religious preference of contraception in Islam, the reaction of the community to the family planning programme (sanctions), family power relation, and characteristics of the community itself (language, CRP). Finally, the positive role of Muslim religious leaders in the family planning programme of Bangladesh is illustrated and the relevance of this programme is discussed in relation to the Indian set-up.

6.3.1 Characteristics of the family planning programme (FPP) in India and Bangladesh

Female sterilisation has been the main method propagated by the Indian family planning programme since its inception (Pachauri 2004). In 1996 the Indian family

planning programme has underwent a paradigm shift (GOI 2000), from a target-oriented approach to a client-centred approach. This client-centred approach is committed towards providing information as well as to make available varied contraceptive choices (including spacing methods) to people. However, it is observed that even though the shift has taken place at the policy level, the change has yet to be implemented in practice (Visaria et al. 1999; Pachauri 2004; Matthews et al. 2009). Additionally, central - and state - level policies on family planning differ considerably (Visaria et al. 1999) which acts as a bottleneck for the effective implementation of a uniform programme throughout the country.

Bangladesh is one of the few Islamic countries to have adopted sterilisation as part of the family-planning programme; additionally; temporary methods, especially pills, have been in ample supply since 1980 (Mannan 2002). The Bangladeshi family planning programme is hailed as a successful programme among analysts worldwide, because fertility decline has taken place in Bangladesh in the absence of the necessary socio-economic development that traditionally accompanies fertility decline. However, the family planning programme of Bangladesh is often criticised for focussing on the effectiveness of contraceptive methods rather than on the health repercussions of the method (Mannan 2002), specifically women's health.

Preferred contraceptive method of Muslims

Based on analysis described in chapter 5 (Table 5.5), it is concluded that Muslims have shown an absolute preference for temporary methods in Bangladesh and relatively higher preference for temporary methods in India. This is in line with previous studies that found that Muslims prefer temporary methods to permanent methods of contraception (Shaikh 2003; Keefe 2006). This preference for temporary methods among Muslims has its root in theology. Quran approves *azl* (coitus interruptus), which is a temporary method of contraception, and this approval of *azl* has led Muslims to believe that Islam approves only temporary methods of contraception (Keefe 2006). This preference for temporary methods of contraception is reflected in a higher incidence of use among Bangladeshi Muslims. The views of

participants of the present research also reiterate the Muslim preference for temporary methods because they perceive it to be in sync with Islamic prescription (Chapter 7). There is a clear demand for temporary methods among Muslims in Bangladesh. Further, the family planning programme of Bangladesh also ensures a greater supply of temporary methods of contraception (Mannan 2002). Hence, Bangladesh is an example of a "supply meets demand" scenario.

As mentioned earlier, a significant proportion of Muslims in India use sterilisation methods even though they are less inclined to use it. This could be because the client-based approach of the Indian family planning programme has yet been unable to overcome the prior programmatic focus on sterilisation as the main method of contraception (Pachauri 2004). Further, the supply of sterilisation in India does not coincide with the religion-based contraceptive need of Muslims for temporary methods. Hence, India is an example of a "mis-match of demand and supply" scenario with regard to contraception. This "mis-match of demand and supply" has probably resulted in lower acceptance of contraception among Muslims in India. In order to substantiate this argument, a Cox regression analysis was performed on the non-sterilized mothers of two children. Through the Cox regression analysis the rate of transition between parity 2 and 3 is explained (results not shown here) for non-sterilised mothers of two children. The controls included in the model are: religious affiliation, individual religiosity, education, standard of living, location, exposure to mass media, age and working status. The results from the Cox regression show that religious group affiliation (being Hindu or Muslim) is not significant, indicating that both religious groups have their third child after the same interval of time. Hence, the greater supply of Islamic-proscribed methods of contraception - sterilisation - is responsible for the low acceptance of contraception among Muslims of India. Consequently, it results in a high fertility trajectory of Muslims in India. In the absence of excessive stress on the sterilisation method, the Indian Muslims will have a similar fertility pattern as the Hindus of India.

From the comparison of family planning programmes in India and Bangladesh what remains implicit is the complex interplay of group dynamics and the designing of family planning programmes in the respective countries. In this chapter it is argued that the programmatic focus on the sterilisation method in India and temporary methods in Bangladesh is not mere coincidence. The Hindu religious dictums are not opposed to any specific method of contraception. Consequently, in order to attain India's demographic goals[25] its family planning programme has adopted sterilisation as the main method of contraception. This is in line with the majority community's religious beliefs. This indicates the lack of awareness and sensitivity of policy planners towards the Islamic religious principles (which is the religion of the largest religious minority in India) that disapproves the use of sterilisation. Hence, this has resulted in a situation in India where the Muslim minority's need for contraception is not met. In Bangladesh even though the sterilisation method is available, in practice, temporary methods of contraception are primarily being supplied. The focus on temporary methods is most likely related to the religious fervour of the majority group, i.e. Muslims, because Islam approves the use of temporary methods of contraception. In both India and Bangladesh the contraceptive method that is made available by the respective family planning programmes caters to the majority group's religious sentiments. The Bangladeshi context has not created any hurdle for the Hindus in Bangladesh because there is no restriction on temporary methods in Hinduism. However, the pro-sterilisation stand of the Indian family planning programme has resulted in creating hurdles for the Muslim minority community in accepting contraception in India.

6.3.2 Community and family reactions to sterilisation in India

The constraints for Muslims in the Indian context are in the form of religious sanctions that are imposed on couples who use Islamic proscribed methods of contraception - sterilisation. Further, reiterating a similar point, McQuillan (1999) argues that the use of contraception by religious groups is influenced by the assessment of socially imposed costs such as religious sanctions that are attached to

[25] Replacement level of fertility.

the contraceptive method. The qualitative data give ample illustration of religious sanctions that operate in the Indian context to dissuade couples from being sterilised.

> [A: According to Islam, operation (sterilisation) is not good. One cannot go on *hajj* (pilgrimage to Mecca). It is like killing babies so it is not allowed in our religion.
> Q: Who has said that operation should not be done?
> A: It is in our Islam. That is the reason everyone says no to operation. While on *hajj*, *namaz* (ritual prayers) is not allowed. That is the reason people say no-no to operation.]
> (Participant 1: Female, 25 years old, urban Bangalore, India, 10 years of education)

> [Q: Has Allah mentioned how many children should be born?
> A: In our religion, operation (sterilisation) is prohibited. People who go for operation, the food that is prepared by them is unfit for *fateha* (offering incense and food along with prayers to Allah).]
> (Participant 2: Female, 22 years old, rural Dharwad, India, illiterate but educated at a *madrasa*)

> [A: ……..the son of my sister-in-law who attends *jammat* (religious gathering to discuss religious topics) says do not do operation.
> Q: Why?
> A: He says it is a sin.]
> (Participant 3: Female, 25 years old, urban Bangalore, India, 5 years of education)

> [Q: In your religion, which method of birth control is said to be permitted?
> A: In our religion, going for operation (sterilisation) is *najayaz* (unethical). It is considered as unethical. Cannot go to any *dargah* (the grave of *pir* - spiritual leaders) if one has undergone operation.]
> (Participant 4: Female, 38 years old, urban Bangalore, India, illiterate)

Those who undergo sterilisation are barred from offering *namaaz* (customary offering of prayer five times a day) during *hajj* (pilgrimage to the city of Mecca). Both *namaaz*

and *hajj* are two most important duties of a devout Muslim and the prohibition to perform these duties sends a strong message to potential transgressors of the existing norms to refrain from using sterilisation. In Karnataka, a culture-specific ritual among the Muslims is the practice of *fateha* (offering incense and food along with prayers to Allah). Sanctions are imposed on women who have undergone sterilisation: the food cooked by them is considered to be unfit for offering *fateha*. Another culture-specific practice in India is that Muslims visit *dargah* (the grave of *pir* - spiritual leaders) to offer prayers. Those women who have been sterilized are not supposed to enter the *dargah.* Further, in their study on Muslims in India, Jeffery and Jeffery, (1997) argue that these religious sanctions might also be a means through which the Muslims in India maintains a boundary distance from the pro-sterilisation family planning programme which symbolises the ideology of the majority Hindu population. Stephenson (2006) based on empirical findings further contends that the districts of India where there is a relatively higher Muslim concentration (20 percent and above) show a lower adoption of sterilisation. This indicates that when Muslims primarily reside with their own community members they experience a heightened level of social control through religious sanctions which acts as a deterrent in the adoption of sterilisation. Group dynamics can influence reproductive behaviour through different underlying processes as suggested by McQuillan (2004); a minority group tends to have higher fertility under a condition where the sense of solidarity or attachment with the in-group is strengthened and when conflict and competition with the out-group exist.

Power relations: the family structure

Family as a social unit plays a crucial role in sustaining religious norms. In the Indian context, in-laws often reside with young couples in the same household and this close physical proximity creates condition for intense social control, also in matters of fertility control.

> [Q: How many children should a woman have?
>
> A: In today's circumstances one is enough. If you want to have both a son and daughter then one son and one daughter is enough

Q: If you want to restrict to two children....then?
A: Then have to get sterilised
Q: Regarding the method of contraception which you intend to use, do you discuss it with your husband?
A: Yes. But I did not tell my mother-in-law because she says no to it.
Q: Why does your mother-in-law say no?
A: She is from the older generation. She does not know about today's circumstances.]
(Participant 1: Female, 25 years old, urban Bangalore, India, 10 years of education)

[Q: What is your opinion about family planning methods?
A: Having one or two is more than enough so we have adopted that in our life. At the time when my wife got sterilised my father was against it and wanted us to have two more children. But I told my mother we have one boy and one girl that is enough so she (wife) should get sterilised.]
(Participant 5: Male, 26 years old, rural Dharwad, India, 14 years of education)

The family system in India upholds the high position of the older generation in the power structure which the younger generation is obliged to obey. An example: the male participant when he disagrees with his father regarding the size of his own family, he expresses his opinion to his mother rather than his father. This is because normatively speaking he is not supposed to "disobey" the patriarch of the family. In the current research there are a few instances when women underwent sterilisation without disclosing it to their husband/in-laws (chapter 7). However, this study argues that not all women will have the courage to go against the system by disregarding the prevalent norms. Additional hurdles are created for the young Muslim couples in India due to religious, communal and social opposition against the sterilisation method as a result of the unequal power relationship and gender norms in India (Saavala 2001). In the following section, the distinct nature of religious communities such as residential segregation and language is described, which can also be instrumental in explaining higher fertility level of Muslims in India.

6.3.3 Concentrated Residential Pocket (CRP): The routes to infrastructural neglect and obstruction of diffusion

The Muslims in India tend to live in CRPs due to security concern resulting from the history of communal riots between Hindus and Muslims in India and this feature adds to their isolation (GOI 2006). These concentrated residential pockets where Muslims reside suffer from socio-economic infrastructural disadvantage (GOI 2006). Inadequate socio-economic infrastructure in terms of health services, educational institutions and communication in the "Muslim space" deters the utilisation of such services by the Muslims. It is a known fact that deficient socio-economic infrastructure has a profound impact on fertility. For instance, education plays a crucial role in the formulation of notions regarding the size of family. Further, it also is a source of correct information regarding reproductive behaviour, specifically family planning practices. Hence, the dearth of educational institutions in the "Muslim space" blocks the routes through which education could possibly influence people's perception regarding reproductive behaviour. Additionally, the absence of health facilities in the "Muslim space" deters the dissemination of right information regarding contraception to the Muslims. It also deters the supply of contraception. Hence, the presence of such socio-economic disadvantages in the "Muslim space" does not create a conducive setting for Muslims to make informed reproductive choices. In addition to the specific residential pattern of Muslims in India there is a linguistic specificity, that is, typical of Muslims in India and in this chapter it is argued that this has important implications for their fertility.

6.3.4 Community characteristics - language as source of diffusion

There is a distinct linguistic character to religion in Karnataka, India, because Muslims speak Dhakani - a language different from the one spoken by the majority community – which is Kannada. Dhakani is a dialect of Urdu, the language spoken by the majority of the Muslims in India. Since Muslims speak a different language, they have a sense of unique identity based on language in addition to religion. It is

observed that the linguistic identity is often used synonymously with religious identity. The following example will serve as an illustration:

> [Q: In your opinion, when a boy has to get married, what does he look for in a bride?
> A: They ask the girl whether she has studied. Has she read the Quran? Does she know how to sew clothes? Has she gone to school? If she has studied then she says yes, if not then she says no. It is like among you Hindus.
> Q: Like?
> A: When a Kannad (Hindu) boy has a job he wants his bride to be educated, it is the same among us Urdu (Muslim) - speaking people.]
> (Participant 6: Female, 24 years, Muslim, rural Dharwad, India, *madrasa* educated)

The Muslim female participant explained her views regarding the attributes expected of a prospective bride, while in her answers she refers to Hindus as Kannad and her own community as Urdu-speaking people. The Muslim linguistic identity (Dhakani) also serves the purpose of maintaining the distinctiveness (boundary) of one's religious identity which is different from the linguistic identity of Hindus (Kannada). The process through which this distinct identity is reiterated is termed as boundary maintenance wherein either group tries to maintain a distinct identity and ensures that there is least similarity of behaviour between communities (Barth 1969). In the process of boundary maintenance, symbols play an important role in generating a sense of shared community belongingness (Cohen 1986), for instance the language Dhakani here serves as the symbol of distinct identity. The process of boundary maintenance also involves resistance to any attempt of assimilation by the community which is maintaining the boundary with the other community. An example of such resistance is reflected through the views expressed by a female participant.

> [My husband bars me from watching Kannada movie because he feels I will become like Hindus.]
> (Participant 7: Female, 40 years of age, urban Bangalore, 5 years of education)

Observation through extensive data collection in Karnataka suggests that the majority of Muslim women in urban Bangalore can speak only one language i.e. Dhakani, whereas the Muslim women in rural Dharwad speak both Kannada and Dhakani. We consider the inability of the Muslim women residing in urban Bangalore to converse in the language of the majority community - Kannada - as an offshoot of residential segregation (CRP) that typically characterises the Muslim community's settlement pattern. This residential segregation and uni-lingual status of Muslim women could possibly create an obstacle for Muslim women in urban Bangalore to interact with other members outside their community. The scope for the interaction of Muslim women with other community members is also small because they live in CRPs and are primarily self-employed, working from their homes. Considering Muslim women's inability to converse in the language of the majority, we hypothesise that this could result in more serious implications for women than for men. This is because the responsibility of fertility control primarily rests with women in the South Asian context, and if they are isolated from the mainstream population this could insulate them from information and insight regarding reproductive health that is channelled through health professionals.

Additionally, the health professionals often speak the language of the majority community (Hindus of Karnataka) - Kannada - simply because they are numerically preponderant. The two Hindu nurses from the maternity hospital in the Bangalore research location were interviewed and asked in which language they communicated with the Muslim women who come to the hospital. They said they speak Hindi (language understandable to Dhakani-speaking people) with Muslim women visiting the maternity home. However, when the nurses were interviewed in Hindi, they could neither comprehend nor speak the language. This confirms our hypothesis; indeed the linguistic isolation of Muslim women in Bangalore and the inability of health personnel to communicate in a mutually understandable language, i.e. Hindi, could obstruct the flow of correct information on reproductive health matters to the Muslim women.

However, in Bangladesh, Muslims and Hindus speak the same language i.e. Bangla. Despite the religious differences a common language has been instrumental in unifying the two communities. In fact, Bangla nationalism is said to be the reason for the Bangla-speaking population of Pakistan to assert their right to self-determination (Barman, Rahman and Siddiqui 2003). This eventually resulted in the creation of Bangladesh as an independent nation in the year 1971. Since the Muslims are a religious majority in Bangladesh and they share a common language with the Hindus, the process of boundary maintenance among Muslims and Hindus in Bangladesh is not very pronounced. For instance, *pohela baisakh* - the first day of the Bangla calendar is celebrated by Bangla-speaking people irrespective of religious group affiliation (Uddin 2006). Bangla is said to have contributed to the secular liberal discourse in Bangladesh (Basu and Amin 2000). Furthermore, the same authors argue that the language Bangla has acted as a catalyst for the diffusion of a favourable attitude towards fertility control among the people of "greater Bengal" – which is now known as West Bengal in India and East Bengal or Bangladesh (Basu and Amin 2000).

6.4 Positive role of religious leaders in Bangladesh: A suggestion for India

The Bangladesh family planning programme has incorporated *imams* (Muslim religious leader) into their programme in order to propagate the virtues of family planning by providing religion-based justification for using contraception (Amin 1997). The *imams* are trained in a liberal interpretation of Islam and they project population control as part of a larger goal i.e. socio-economic development of the country. For instance, the training programme developed by the Islamic Foundation has its third chapter dedicated to family welfare, covering a range of issues on reproduction including the proximate determinants of fertility i.e. marriage, contraception and breastfeeding (IFB 2009). The content of the training programme indicates that the Bangladesh government is aware of the positive role that *imams* can

play in reproductive matters. The text that follows will illustrate the potential power and credibility that religious leaders have in issues concerning reproductive health.

[Q: How many children should one have? Why?
A: The government created awareness that parents should not have more than two children. But *Allah Rabbul Alamin* said in the Quran "Do not kill your children in the fear of the expense of bringing them up." However, *Allah* has further reasoned that, "You must have control over *akida* (expenditure, movements) of your children. So do not have so many children as a result of which it gets out of your control." Looking at the present population of Bangladesh, I think that it is not good to have more than two children. But, it must be done in the light of the Quran and Hadith.

Q: Do you have any knowledge about birth control methods?
A: I know about pills, condoms, to insert a stick in the arm for five years (Norplant), injection etc.
Q: Which one is the most popular?
A: Here, pills are the most popular, followed by condoms. As people do not have a proper knowledge about other methods, these two are the most popular.

Q: Do people keep a gap of time between two children?
A: People hardly maintain any gap.
Q: What should be the duration of gap?
A: I think one should keep a two-year gap.
Q: Why?
A: Today I conducted *milad* (religious gathering) at a house where a baby was born without any spacing after the first child. The second baby died after 5 days of its birth. Though life and death are in the hands of *Allah*, we have to be aware of these things. In this case, the first baby was being breastfed; they should not have had the second child so soon.

Q: Do many people undergo sterilisation here?
A: Very few people do that.
Q: Why is it so?

A: Sometimes people who are aware and do not want any more children, they do this. It is a permanent method but it is not popular.]

(Participant 8, Imam 1: Male, 36 years, completed *kamil*, 14 years of Islamic education)

[Q: How many babies should a person have?
A: There are different views about this. Many Islamic intellectuals think that people should not use birth control methods even though they cannot economically support the child but only when there is a threat to the mother and the child's life. But I think one should consider issues such as food, shelter and social security, and how to make a good human being out of the child (upbringing). In my opinion it is not good to have more than 2-3 children.

Q: Which birth control methods are you aware of?
A: I know about the birth control methods such as pills, condoms, and the natural rules of the body (rhythm), injection, *azl* (withdrawal) and so on.
Q: Which one do the people use the most?
A: The two most used methods are pills and condoms. However, these are not *jayej* (approved) according to Islam. Islam approves only *azl* method and the method of counting the safe period of the women (rhythm method).

Q: How is sterilisation perceived?
A: People never did sterilisation before. Now when the doctors in the hospital or clinic do caesarean section during delivery, they ask the guardians whether the woman already has two children and whether they are interested to do it. If the guardians agree, they do sterilisation.]
(Participant 9, Imam 2: Male, 38, completed *kamil*, 16 years of Islamic education by the Islamic Foundation)

The qualitative data clearly illustrate that Bangladeshi *imams* hold a liberal view of religion in matters of family control and contraception. One of the *imam* participants of this research refers to the *akida* philosophy of Islam in order to justify the small size of a family. According to him, having a big family will result in loss of control

over a child's upbringing and he stresses the need to restrict the size of the family. However, he argues that it should be done through family planning practices approved by the Quran and hadith. The views expressed by religious leaders suggest that they are far removed from a fatalistic worldview which is often associated with religious leaders; on the contrary, they seem to magnify the importance of individual responsibility in matters of reproductive health. When the *imams* of Bangladesh, who are the repository of religious authority, hold such liberal views regarding family planning, the current study interprets this as conducive to creating a congenial atmosphere where the Muslims in Bangladesh are more likely to feel confident in adopting family planning practices.

The present research has asked the participants of the survey regarding their source of religious knowledge. The four sources of religious philosophy cited by them were: religious texts, religious leaders, both religious texts and leaders and a category comprising elders/family members/relatives. The category elders/family members/relatives constitute an informal source of religious philosophy. It is evident from the table 6.1 that in Bangladesh, the religious leaders play a relatively bigger role in informing the religious philosophy to its adherents than in the Indian context.

Table 6.1: Sources of religious philosophy cited by Muslim women in India and Bangladesh (%).

	Indian Muslim	**Bangladeshi Muslim**
Source of religious information		
Religious text	10	0.5
Religious leaders	20.5	65.8
Religious text and leaders	3	7.4
Elders/family members/relatives	66.5	26.2
N	800	

In the case of India, Muslims get to know about Islamic philosophy primarily through oral tradition. By oral tradition we mean informal or non-codified sources of information regarding religious rules. The present study perceives religious understanding attained through the oral tradition to have fewer avenues for the

reformation of Islamic principles. For instance, in Bangladesh the religious leaders who are trained in a liberal interpretation of Islam have played a crucial role in reforming the conservative religious attitude towards reproduction. However, in the Indian context, it is clear that religious leaders do not play an important role in the religious lives of Muslims. Further, any attempt to bring about reformation by training religious leaders has not been undertaken by the government of India. Hence, we assume that the Muslim couples in India might find themselves in rather confronting situations when they decide to use religiously proscribed methods of contraception in the absence of *imams* trained in liberal interpretation of Islam.

The Indian government seems to have realised the importance of religious leaders in matters of reproductive health because the National Population Policy (NPP)-2000 has proposed the inclusion of religious leaders in the family planning programme. However, an elaboration of the manner in which the religious leaders are to be incorporated in the family planning programme is missing (Iyer 2002).

6.5 Conclusion and recommendations

The present chapter untangled the puzzle behind the high fertility trajectory among Muslims in India by comparing the contexts of Muslim fertility behaviour in India and Bangladesh. Earlier, the three conditions under which religion is likely to influence reproductive behaviour were outlined (McQuillin 2004). By applying these three conditions, we can explain the higher fertility of Muslims in India. First, Islam pronounces certain rules that have the potential to influence fertility behaviour. Second, in order to ensure conformity to these religious rules, the study has observed the prevalence of religious sanction among the Muslims of India. Finally, Muslims in India tend to live in CRPs as a result of the communal conflicts, which create condition for enhancing solidarity within the community. Further, it has been argued by the Sachar committee report (GOI 2006) that such settlement pattern boosts the sense of security among Muslims in India. Taking this argument further we assume that such settlement pattern is likely to enhance the sense of solidarity or attachment within the community which is the third condition outlined by McQuillin (2004).

The previous chapter (chapter 5) reveals that both Muslim individuals as well as the population policies of India and Bangladesh are aspiring to realise a small family norm. In the current chapter we argue that the Muslims of India are not able to realise their fertility aspiration due to various hurdles they face in the Indian context. The constraints can broadly be categorised into: characteristics of the family planning programmes (different methods propagated), religious preference of contraception in Islam, the reaction of the community to the family planning programme (sanctions), family power relation, and characteristics of the community itself (language, CRP). The recommendations made by the current chapter are directed towards overcoming the hurdles that are faced by the Muslims in India by creating a congenial set-up for them to realise their aspired fertility level and trajectory.

On the one hand, the Indian family planning programme has primarily focused on sterilisation and on the other hand, sterilisation is restricted as per the Islamic principles. Hence, Muslim couples in India get constrained because the sterilisation method - an Islamic-proscribed method of contraception - is supplied by the Indian family planning programme. This client-centred approach of the Indian family planning programme has not been realised yet. Hence there is a need to ensure that in practice more contraceptive choices and information are made available by the Indian family planning programme. Specifically, temporary methods are thought to be approved by Islam; hence, there is a need to supply this method in view of the religious sentiments of Muslims in India. This will ease the biggest religious as well as community level hurdle (sanctions, family power relations) for Muslims in realising their desired family size.

In view of the community-level characteristics of Muslim women in urban Karnataka, India, who can speak only one language (Dhakani) there is a need to recruit bi-lingual health personnel in the CRP. If the health care providers are able to speak Hindi, which is understandable to Muslims, this could easily solve the linguistic barrier between the health care provider and the client. Additionally, owing to the inter-group dynamics in India, the current research recommends recruitment of Muslim health

personnel in Muslim CRPs. This will enhance the sense of belongingness between the client and the provider of health services.

A part of the constraint that is faced by Indian Muslims results from the socio-economic disadvantaged position of their community. Another is a result of the contextual community characteristics (CRP and language). Hence, there is a need to effect socio-economic equalisation between religious communities in India.

The purpose of comparing the context of Muslims in India and Bangladesh is not confined to finding the reason behind the high Muslim fertility trajectory in India. The purpose of this comparison is also to learn some lessons from each other. One lesson that could be learnt by the Indian family planning programme is the *imam* (Muslim religious leaders) training programme of Bangladesh. In Bangladesh the religious leaders have played a positive role as facilitators of change in the field of reproductive health. By including religious leaders in the family planning programme as suggested by the National Population Policy 2000 the policy makers in India have recognised the potential role which religious leaders can play in reproductive matters. However, a concrete plan of action has not been executed. This could be done by developing a training programme for *imams* in India along similar lines as the training programme for *imams* in Bangladesh. These *imams* can be trained in a liberal interpretation of Islam regarding reproductive matters. Since religious leaders do not play a major role in informing people about religious philosophy in India, their involvement could be enhanced in the day-to-day lives of Muslims by organising religious gatherings to discuss worldly issues such as reproductive health. Further, if the *imams* are trained in a liberal interpretation of Islam, this could play a major role in de-mystification of the religious sanctions prevalent among Muslims in India. Consequently, it could also reduce the level of social constraint faced by young Muslim couples who are keen to plan their family size. In Karnataka, the young Muslim girls receive religious education from female religious teachers, but that training is often limited to learning Arabic and codes of conduct for the ideal Muslim woman. Taking the gender segregation prevalent in Muslim society into account, the female religious teachers

should also be included in the training programme which is oriented towards a liberal interpretation of Islam. These trained female religious teachers could give reproductive health information to Muslim women.

The chapter that follows explores the role of agency in realising reproductive aspiration; however, within the ambit of Islamic principles that guide reproductive behaviour. Owing to the comparative nature of the current research, the chapter further examines how the role of agency differs across Indian and Bangladeshi contexts.

Chapter 7: Lived religion: negotiating Islam to realise reproductive aspirations

7.1 Introduction

The stand of Islam on issues of reproduction, [26] specifically on contraception and abortion, has been subject to contestation (Maguire 2003; Shaikh 2003). Islam is said to restrict family planning through its strictures against contraception and induced abortion. However, in recent times Islam is perceived through the lens of flexibility in terms of permissibility of contraception and levels of permissibility of abortion (Obermeyer 1992; Shaikh 2003). Despite the differential views of Islamic jurisprudence on matters of reproduction when it comes to the everyday life situation the adherents exercise discretion in their reproductive behaviour. In this chapter, we argue that religion indeed influences the actor's reproduction but that this is done through a dynamic process of negotiation between structure-religion and the agent who ascribes a new meaning to religion in everyday life. As such, the metaphor of lived religion arises, that is religion as it is perceived as well as lived by the individual.[27] Lived religion as a concept elucidates the process of negotiation of religion by the actor who defines the situation and justifies reproductive decisions. We discuss the different strategies used by actors to negotiate existing religious norms in order to realise their own reproductive aspirations.

[26] In this chapter, we consciously use the term reproduction, not fertility. Since we wish to explore the process through which actors negotiate religion in matters of reproduction it was considered appropriate to use the term reproduction rather than fertility.

[27] The concept of "lived religion" is used by Hall, 1997 to study the American religious history through religious practices on a daily basis.

Studying Muslim reproduction is relevant in this era because of its highly politicised and often contested nature (e.g. in India, see Basu 1997; Jeffery and Jeffery 2002; Jeffery and Jeffery 2005). The Muslim community is perceived to be escalating their fertility with an agenda to outnumber the other religious communities (Joshi et al. 2004; Huntington 1996 and Eberstadt 2001; cf. Johnson-Hanks 2006). Contesting this view, there are scholars (Jones 2003; Johnson-Hanks 2006) who argue that no one single coherent "Muslim fertility" can be arrived at cross-nationally. These contestations are often made based on fertility differentials which are macro-level aggregates such as children ever born, completed family size, total fertility rate (Moulasha and Rao 1999; Bhat and Zavier 2005; Dharmalingam and Morgan 2004). These macro-level trends however do not give any indication of the dynamism in religion that exists in a day-to-day context. While conclusions about the link between religion and fertility often brand a particular religion as being pro-natalist, these are based on fertility differentials only.

The underlying mechanisms and religious norms are often left open to speculation. The conclusions are often also devoid of the voices of the subjects themselves with regard to what holds significance in their lives and in what ways religion in reality influences their reproductive choices. In this chapter, we approach the issue by delving deeper into the processural aspects of the link between religion and reproduction through the voices of adherents of Islam. Further, we reflect on the context-specific features of India and Bangladesh based on which strategies are developed by Muslim women in order to negotiate religion in the domain of reproduction.

Population policies of India and Bangladesh are both committed to control population. In the case of India, the population policies have largely been target-oriented (Narayana et al. 1998) and focused strongly on one method of contraception that is sterilisation (Srinivasan 1983). Lately, in 1996, the Indian family planning programme has undergone a paradigm shift (GOI 2000), from a target-oriented approach to a client-centred approach. This client-centred approach is committed

towards providing information as well as to making available varied contraceptive choices (including spacing methods) to people. Though the Indian population policy has made an "official" paradigm shift since 1996 towards providing more choices in contraceptives, in practice sterilisation is still the dominant method that is advocated (Pachauri 2004). This is reflected in the higher use of sterilisation and relatively lower use of temporary methods in India. Induced abortion is legal up to 7 weeks in India, according to the Medical Termination of Pregnancy Act of 1971.

Bangladesh is one of the few Islamic countries to have adopted sterilisation as part of the family-planning programme; additionally, temporary methods, especially pills, have been in ample supply since 1980 (Mannan 2002). In the case of Bangladesh, the population policy has focussed largely on family planning, especially through spacing methods (oral pill, IUD, Norplant, condom). The Bangladesh Penal Code of 1989 terms induced abortion as illegal[28] (Bhiwandiwala et al. 1982). However, menstrual regulation in the early stages of pregnancy has been allowed in Bangladesh since 1970 (Akhter and Rider 1983). Further, menstrual regulation often serves the purpose of averting pregnancy (Dixon-Muller 1988; see also the discussion later in this chapter).

7.2 Theoretical framework for the study

As an important component of social structure, religion influences the code of conduct and behaviour of its adherents (Giddens 1984; Hardcastle et al. 2005). However, this is not a uni-dimensional interaction; there are very distinctly diversified interactions between the structure (macro) and agent (micro) that are best expressed through the concept of duality of structure (Giddens 1979). Further, Giddens (1984) reasons, structure through its normative component influences actors and ensures conformity to the norms through sanctions. However, actors *conform* to as well as *transgress* these norms (Tucker 1998) in order to make these suit their life situation. Giddens defines norms as collective knowledge of social rules (Tucker 1998). In cases of transgression, the actor tries to explain the circumstances under which that

[28] Induced abortion is allowed only when the mother's life is threatened

particular act of transgression has taken place (Giddens 1991). The agency of the actor then lies in giving justification for such a transgression. There exists an ongoing endeavour on the part of the actor to strike a balance between religious prescriptions and individual aspirations, in our case the actor's reproductive aspirations. This chapter seeks to examine the dynamism between the macro and micro order, which is inherent in the process through which women negotiate Islam in order to realise their reproductive aspiration. In order to put into perspective the emergent themes of our qualitative data analysis we have used Giddens's structuration theory (1979, 1984) which serves as an overarching framework for this chapter.

7.3 Methodology

This chapter draws from the experiences and opinions of Muslim women situated in the cross-cultural context of India and Bangladesh. These interviews were conducted among women living in rural and urban locations: rural Dharwad and urban Bangalore in Karnataka (India) and rural Matlab and urban Dhaka (Bangladesh). The current chapter adopts a qualitative case-oriented approach.

Qualitative data for this chapter are drawn from 32 in-depth interviews conducted among Muslim women in India and Bangladesh. Out of the total number, twelve interviews have been quoted in this chapter. The interviews cited are the ones that were highly illustrative in explaining the research issues. Details regarding recruitment of research participants (section 2.8.1) are elaborated in chapter 2 of this book.

The interviews were mostly conducted in two languages - Dhakani (language used by the Muslim population in Karnataka) in India and Bangla (language spoken by both Muslims and Hindus) in Bangladesh. One interview in India was conducted in English. A lot of attention has been paid to the transcription of the interviews in the native languages (Dhakani and Bangla) and then to its translation in English. It was most important to ensure that the translated English text remained faithful to the flavour and meaning of the opinion expressed by the interviewed women.

The in-depth interviews were analysed using grounded theory developed by Glaser and Strauss (1967) through which the theory emerges from the collected data.

Grounded theory is an inductive procedure of data analysis to build middle-range theory through successive levels of data analysis and conceptual development (Charmaz 2005). The method was introduced by Glaser and Strauss (1967) to develop theory involving interplay between data analysis and collection (Strauss and Corbin 1994). Grounded theory involves interpretation of the actor's point of view which makes it imperative to include the voices of the people interviewed. Attaining conceptual density with meaningful variations is one of the crucial dimensions of developing theory through this methodology. The procedure for generating the theory involves asking concept-related questions, theoretical sampling, coding and attaining conceptual density (Strauss and Corbin 1994). The understanding of the process through the linkages between various concepts can also be presented diagrammatically to integrate the macro and micro orders into a coherent theory (Corbin and Strauss 1988 and Corbin 1990; cf. Strauss and Corbin 1994). The presentation of the process is done in a discursive manner which is "embedded in thick context of description and conceptual writing" (Strauss and Corbin 1994:278). Predictability can be attained through the method by specifying the conditions under which similar consequences are likely to occur (Strauss and Corbin 1994).

In the following section, we sequentially describe the different building blocks of the theoretical framework resulting from our analysis. The building blocks are categorised under two broad headings, namely the macro normative order or the structure and the micro negotiation order or the agency. The final theoretical framework, put into perspective by employing Giddens's structuration theory, is elucidated in the concluding section.

7.4 Macro normative order

The building block of the macro normative order extensively elaborates women's view of Islamic norms on reproduction that centre on childbearing, contraception, and induced abortion. Norms are the collective knowledge of social rules. Norms in this

study are an emic perception of Islamic prescription and proscription in matters of reproduction. The other important component in this block, which is an extension of the norms, is constituted by the religious sanctions that a Muslim woman has to endure on the occasion of transgression of the religious norms. In each of the building blocks the interpretation of what was said during the interview is elaborated first before the excerpt is reproduced.

Religious norm: childbearing and contraception

Here, we basically operationalise religious norms from the women's emic perception of Islamic principles as understood and performed by them in their daily lives. Women were asked what according to them is the stand of Islam in matters of reproduction. When women in India and Bangladesh were asked about the stand of their religion on the number of children they were expected to bear, they were of the opinion that their religion encourages them to have as many children as Allah gives them. According to the women in India and Bangladesh, Islam does not view human intervention (family planning through contraception and induced abortion) in reproduction favourably. This is perceived as an interference with the will of Allah or the creator who made their bodies. The ideal typical view of Islam in matters of reproduction views contraception as impermissible. According to one of the women, Allah is the creator of every organ in the body and each organ has its purpose. Any violation of the organ by altering its function (contraception controls the functioning of uterus) through human action would imply an interference with the creator's creation. Because of this, human volition of any form such as control of family size, that is the use of contraception, is not encouraged. Often the prophets and the older generation are said to have set an example for the present generation to follow the religious norms of reproduction.

> [I: What does your religion say about this? How many children should there be?
> R: In our religion it is stated that the more children are born, the greater is the happiness.]
> (Participant 1: 38 years old, urban Bangalore, India, illiterate)

[I: Why were you asked not to get operated (sterilised)?
R: The "sack" for the baby (uterus) is cut, that' the reason. Allah has made it then why do you have to violate that? It is a *gunah* (sin) as we have been told. You do not make it yourself. That is made by Allah, so why do you have to do anything to it? That is why it is forbidden. If one has no hand, one cannot do work, if one has no eyes then one cannot see. Then in that thing (uterus) why do we have to do anything? That is given by Allah.]
(Participant 2: 25 years old, urban Bangalore, India, 5 years of education)

[I: In the religion of Islam is there anything said about birth control methods? Which one should be used and which one should not be used?
R: If the religion of Islam is followed faithfully then none of the methods can be used. Before us our religious prophets, father, mother, maternal grandmother and paternal grandmother have not used anything. They have simply had children which stopped in the natural course. Our forefathers and prophets have done so because of religious prohibition. Birth control is like stopping by obstructing, which is not right according to religion. That is why birth control methods are wrong according to religion.]
(Participant 3: 31 years old, rural Matlab, Bangladesh, 12 years of education)

[I: What do the *imam* and *maulavi* (religious leaders) say about birth control methods?
R: Yes, I hear that they tell us not to use these methods. Let all the children which Allah gives be born. When we go to do our work they pass nasty comments about us. They say, "These people (child health workers) have come to spoil women." Such things were not there in the past.]
(Participant 4: 34 years old, rural Matlab, Bangladesh, 15 years of education, child health worker)

Religious norm: induced abortion

Similar to contraception, induced abortion is also a taboo in Islam. The religious connotation attached to induced abortion (referred to as abortion by the women) is mostly negative. Muslim women in Karnataka, India, refer to an induced abortion as *baccha girana (*throwing a child). It is considered a sin and equated with taking a life.

Therefore, there is a strict prohibition on resorting to induced abortion. The reason for the prohibition is also because it is an act of human intervention into the domain of Allah, which is giving or taking life. Life after death is extremely valued in the religion of Islam and resorting to induced abortion is perceived to result in punishment after death, where the mother is shown the door of hell and not of heaven, the desired abode after death. A woman who has undergone an induced abortion has to confront her aborted child who will question her action and blame the mother for denying the child the right to live.

> [I: Some women "throw their child" (abort). About that matter, what were you told?
> R: Should not throw a child.
> I: Why not?
> R: Because Allah has given it. On the last day, the child will question us. When we are on the way to Hell. "Hey mother why did you not allow me into this world because I would have taken you to heaven. Why did you not bring me into this world? Then the child starts quarrelling.]
> (Participant 5: 22 years old, rural Dharwad, India, illiterate but educated at a *madrasa*)

> [I: You said that you go to *jammat* (gathering for religious sermons), what do they say about MR (menstrual regulation)?
> R: They said not to do it. They say, let all the children given by pure Allah be born. This is a *gunah* (sin).]
> (Participant 6: 34 years old, urban Dhaka, Bangladesh, 5 years of education)

Religious sanction against transgression (sterilisation)

Since the adherents are supposed to abide by religious norms, the mechanism to restrict transgression is through imposition of religious sanction. Additionally, in Islam, great importance is attached to life after death. Hence, sanctions can be imposed either during "present life" or "after life". Additionally, there are four important duties of devout Muslim namely: *namaaz* (pray five times a day), *roja* (ritual fasting for one month during the month of Ramadan), *hajj* (pilgrimage to the city of Mecca), and *zakat* (giving alms to the needy). Therefore, compliance with

religious reproductive norms has been ensured by imposing sanctions on the transgressor by restricting performance of religious duties.

The qualitative data reveal that sterilisation is highly condemned in the Islamic tradition. Sterilisation is considered to be an act of ultimate interference with the will of Allah by the Muslim community. As a result, sterilised women are barred from offering *namaaz* during *Hajj*. In Karnataka, a culture-specific ritual among the Muslims is the practice of *fateha* (offering incense and food along with prayers to Allah). Sanction is imposed on the woman who has undergone sterilisation; the food she cooks is unfit for offering *fateha*. In India, another culture-specific practice is that of visiting *dargah* (the grave of *pir* - spiritual leaders). Those women who have been sterilized cannot enter the *dargah.*

> [R: According to Islam, operation (sterilisation) is not good. Cannot go on *hajj*. It is like killing babies so it is not allowed in our religion.
> I: Who has said that operation should not be done?
> R: It is in our Islam. That is the reason everyone says no to operation. While on *hajj*, *namaz* is not allowed. That is the reason people say no-no to operation.]
> (Participant 12: 25 years old, urban Bangalore, India, 10 years of education)

> [I: Has Allah mentioned how many children should be born?
> R: In our religion, operation (sterilisation) is prohibited. People who go for operation, the food that is prepared by them is unfit for *fateha*.]
> (Participant 5: 22 years old, rural Dharwad, India, illiterate but educated at a *madrasa*)

> [R: The son of my sister-in-law who visits *jammat* says do not do the operation.
> I: Why?
> R: He says it is a *gunah* (sin).]
> (Participant 2: 25 years old, urban Bangalore, India, 5 years of education)

> [I: In your religion, which method of birth control is said to be permitted?

R: In our religion, going for operation (sterilisation) is *najayaz* (unethical). It is considered as unethical. Cannot go to any *dargah* if one has undergone operation.]
(Participant 1: 38 years old, urban Bangalore, India, illiterate)

It is important to note that religious sanctions for undergoing sterilisation have been elucidated in detail only by the Muslim women of India. This might be the case due to the pro-sterilisation stand of Indian family planning programme and instances of coercive sterilisation campaigns in the past (Iyer and Jessani 1999). Since sterilisation - the focus of the family planning programme in India – is against the dictates of Islam, in order to ensure adherence to the dictum the element of fear has been reinforced among the potential transgressors through the religious sanctions.

7.5 Micro negotiation order

This section on the micro negotiation order elaborates on the agency that is exercised by women in the act of balancing religious prescriptions and individual reproductive aspirations. The micro negotiation order illustrates a woman's reflexivity in taking decisions about her reproductive life. The interpretation of the qualitative data is discussed first and then the data are presented in verbatim in the following.

Reinterpretation of religion

Religious norms inform adherents of religious obligations and restrictions. However, the basic premise of these norms can be questioned through reinterpretations. In day-to-day life, religious norms are often unwritten, which enables those who are interested in the issue to go back to the verses in the Quran and to arrive at their own interpretation. Those who reinterpret, try to reason out the applicability of the religious norms in daily life. These interpretations are given by scholars who have extensively studied Islamic theology.

As a result of this reinterpretation, some women appear to have considered the matter of birth control as a personal issue. One Muslim woman in India points out that the religious norms are often erroneous interpretations by human beings. According to one of these interpretations, religion is said to approve the use of contraception in

order to avoid an induced abortion. Hence, women interpret that using contraception is a lesser sin than undergoing induced abortion as induced abortion is prohibited by Islam. The Islamic view of barring induced abortion is correct according to a Bangladeshi woman because it has adverse consequences on a woman's health.

I: About contraception what do they say?
R: They told us not to use family planning
I: Do you agree with that?
R: I just told you that this decision is taken personally. How we are, what we earn.
I: What do the sermons from the media teach you?
R: They show the right path. We have many misconceptions. Whatever the Muslims say right now, it is totally wrong. What they are doing is entirely different from what is mentioned in the Quran.
(Participant 7: 23 years old, urban Bangalore, India, 12 years of education, with a diploma in computer science, interview in English)

[I: All these methods that we discuss right now, is there a prohibition on any, due to religious reasons?
R: Actually according to religion there is no prohibition on any method. It is only wrong interpretation by humans. In all the methods, what I feel is, there is restriction on sterilisation because it can not be maintained (no scope for change). In the religion of Islam, there is no other kind of restrictions on methods.]
(Participant 8: 26 years old, urban Dhaka, Bangladesh, Master's degree)

[I: What does religion say about abortion?
R: It is definitely forbidden. In reality, religion is not fanatic. If there is something good then it is not prohibited. Only what is bad is prohibited. Abortion creates several problems for the physical health of a woman because of which she suffers.]
(Participant 8: 26 years old, urban Dhaka, Bangladesh, Master's degree)

[I: What does religion say about MR (menstrual regulation)?

R: Religion prohibits it. It says a child is a life, so do not take it. One has to use a birth control method, there are so many of them. It is necessary to be cautious. Do not waste a life.]

(Participant 9: 32 years old, urban Dhaka, Bangladesh, 10 years of education)

Who is samajhdar (intelligent) and bujhte paiche (people who have understood)?

One Indian woman interprets the religious norms in a personalised way, but also analyses the application of the norms to the contemporary situation. This makes her reflect on the reproductive behaviour of others in her own community. A woman in India is critical of those in her community who have many children. The criticism is directed at the attitude of people who have bigger families, since the people with bigger families consider children to be Allah's gift as a result of which they do not restrict the size of their family. People who have exercised their agency and have small families (using contraception) are considered to be *samajhdar* (intelligent in Dhakani) or *bujhte paiche* (in Bangla people who have understood) and they earn appreciation from these women participants in India as well as Bangladesh.

[R: In our religion, there is no one who has been operated (sterilised) after having two or three children. They say it is Allah's blessing, what can we do? But if someone is *samajhdar* (intelligent) and educated, then they go and get operated.]

(Participant 1: 38 years old, urban Bangalore, India, illiterate)

[R: Yes, I hear they (religious leaders) say that we shouldn't use it. Let as many children as Allah gives be born….But now it seems that many have *bujhte paiche* (understood) that it is right to make use of methods (contraception). If a method is used things will work out well.]

(Participant 11: 34 years old, rural Matlab, Bangladesh, Bachelor's degree)

Dilemma: torn between religion and reproductive aspiration

The process through which decisions about reproduction are made is not a straightforward one. While planning the size of family, there exists in the same frame an awareness of whether the decision coincides with the religious prescriptions. Often the woman finds herself in a dilemma because the religious norms on the use of

contraception and her reproductive aspirations do not go hand in hand. Even with the knowledge of religious prohibition, an Indian woman who undergoes sterilisation has resigned to her state and considers *hajj* to be a matter of destiny. A sterilised woman in India forfeits her desire to visit *hajj* because she faces religious sanction. However, she expects to be forgiven by Allah. Even though she has undergone sterilisation. She perceives her action as a violation against the prescribed norm.

A Bangladeshi woman faces a dilemma as to the validity of religious prohibition on contraception in the contemporary context. She reasons that in the past the different methods of contraception were not available and hence people did not use them. Further, she reasons, at present it is not feasible to support a large family due to economic constraints. She finds herself amidst a dilemma because on the one hand she is aware of economic constraints in giving a good upbringing to her child. On the other hand, she is aware of the religious proscription on the use of contraception and induced abortion. In such a situation, the woman herself raises the question, whether it would be fair on her part to bear a child without the ability to feed, clothe, or educate the child.

> [I: What is your opinion in this matter (sterilisation)?
> R: *Hajj* is a matter of destiny. It is not there in everyone's destiny. The one to forgive here is Allah.]
> (Participant 12: 25 years old, urban Bangalore, India, 10 years of education)

> [I: Do you believe in it (religious norm regarding contraception)?
> R: Only Allah knows whether doing this is a *gunah* (sin) or not. I do not disbelieve it nor can I bring myself to believe it. This is Allah's ruling for us. In the past, it (contraceptive) was not available but now it is there and it is right to use it. If there is a child but I am not able to educate, am not able to feed nor able to clothe it then that is also suffering! But if I have one child then I can do everything properly. That is why using it is good.]
> (Participant 6: 34 years old, urban Dhaka, Bangladesh, 5 years of education)

Critical of the situation: sanction and leaders

The Muslim women in India and Bangladesh have shown their scepticism towards religious norms which have failed to convince them. They have difficulties in accepting certain sanctions or religious leaders that seem unfair to them. The Muslim women do not accept the preaching of the religious leaders without first scrutinizing whether the leaders in reality practise what they preach. For example, one of the Bangladeshi woman questions the credibility of a religious leader who advises others to have as many children as possible, but he himself has a small family. She is not ready to accept that argument and is convinced that the leader must be using some method of contraception. It is important to note that religious leaders play an important role in the reproductive lives of women in Bangladesh (see chapter 6). The criticism of the religious leader has been voiced only in the context of Bangladesh.

Since religious sanctions on undergoing sterilisation are typical of the Indian context, criticism against sanctions is only articulated by Muslim women of India. An Indian Muslim woman questions the appropriateness of these sanctions and considers them to be unfair. The resistance becomes evident when a woman says it is wrong to prohibit women from entering *dargah* after being sterilised. It is wrong, according to her, because this sanction disregards the well-being of the woman. By barring the sterilisation method the sanction disregards the well-being of the woman because she is expected to bear many children. She reasons that repeated child bearing is not good for the woman's health. It is important to note that in the Indian woman's frame of knowledge, sterilisation is perceived to be the only reliable method of contraception. This is indicative of the focus of family planning programme in India which primarily projects sterilisation as the main method of contraception:

> [R: If one undergoes an operation she is barred from visiting *dargah*. But I say this is wrong. If a woman bears many children then in what condition will she be? This also has to be thought through.]
> (Participant 1: 38 years old, urban Bangalore, India, illiterate)

[I: Regarding family what do the *huzur* and *maulabi* (religious leaders) say? How many children should a woman bear?

R: Yes, they say that! If you use contraception, it is not good. But they themselves use it.

I: They also do that?

R: If it is not used then is it possible to have only two, three children? They say that at the *waaz* (religious gathering) but they themselves use it.

I: How do you know that?"

R: Have I not seen! One *huzur* was teaching at the w*aaz* but he has only two children. Is it not a possibility that they have one child less or two children more? Do they not use some method?]

(Participant 10: 36 years old, urban Dhaka, Bangladesh, 9 years of education)

People plan the size of family, use contraception and undergo induced abortions

Though women in India and Bangladesh are faced with the dilemma regarding the use of religiously proscribed methods they show support for the use of contraception and family planning. Further, the reinterpretation of religious norms and scepticism towards the system are translated into action. As mentioned earlier, the religious sanctions are typical of the Indian context. The Muslim women in India face greater opposition from their family members on the use of sterilisation and induced abortion. Consequently, Indian Muslim women have developed strategies unique to the Indian context. Sometimes women have continued their use of contraception and secretly undergone induced abortion even though they expect trouble from their family members. The agency exercised by Indian women is evident: they show a proactive stand by planning their family size even though it runs contrary to religious norms and their knowledge of possible sanctions. They show courage in using contraception even amidst opposition in the form of sanctions and also from immediate family members.

[I: You have mentioned earlier that you got a Copper-T inserted without telling anyone?

R: I did that because my husband did not like it but I had three children already so what could I have done?]
(Participant 1: 38 years old, urban Bangalore, India, illiterate)

[I: Do you speak to your husband about contraception?
R: No, he does not know anything about it. My father-in-law and mother-in-law have approved so there is no need.
I: Then you do not speak to your husband about this?
R: He does not like this. He does not agree to operation (sterilisation). This is because this is not approved in our religion but my father-in-law and mother-in-law accept it so it is alright.]
(Participant 2: 25 years old, urban Bangalore, India, 5 years of education)

[I: What do your husband and in-laws think about this (induced abortion)? When you went for it….
R: They do not know about it
I: Why did you not tell them?
R: If they had known, they would have quarrelled so I did not say anything.]
(Participant 1: 38 years old, urban Bangalore, India, illiterate)

[R: He (brother-in-law) will not eat "from my hand" (after sterilisation). That is the reason we do not say anything but just get it done. He says you can get these things (temporary methods) use them, why do you have to do this (sterilisation)? However, if I want to have only two children then what should I do?]
(Participant 2: 25 years old, urban Bangalore, India, 5 years of education)

Definition of situation for using contraception

Since religious sanctions and opposition from immediate family regarding the use of contraception is very specific to the Indian context, Muslim women in India feel obliged to justify the use of religiously proscribed methods. The following and the verbatim quotes point out clearly under what circumstance women in India use contraception. The women for example indicate that planning a small family is necessary as it is economically not feasible to maintain a large family. They contend that in order to ensure a good upbringing for the child, it is necessary to have a small

family. Religion prohibits sterilisation but having many children is not feasible. It is unacceptable for a woman to be in a situation, in which a child is born but she is unable to provide the child all that it needs for a good upbringing. Furthermore, ensuring women's own well-being surfaces as a reason for limiting the family size. The main point however which the women voice is that people should have only as many children as they can economically support.

> [I: In your view, how many boys and girls should there be in a house?
> R: Two sons, two daughters or one son and one daughter. A big family does not look good. If you have more children then it creates trouble. We should have children according to our capacity. Only those that we can feed should be born. It is not right to just bear children and put them into the world. Later they will say, gave birth and left silently (without taking care). Have no ability to feed but gave birth!]
> (Participant 2: 25 years old, urban Bangalore, India, 5 years of education)

> [R: Under the present circumstance it is not possible to have many children. Nowadays it is difficult to get children educated. If I have to give good education then I have to stop at two children. Operation (sterilisation) is not advisable but it is not possible to bring up many children, it creates problems.]
> (Participant 12: 25 years old, urban Bangalore, India, 10 years of education)

> [I: Do you agree to it (stand of religion on barring contraception)?
> R: It creates problems for the woman. Children are born year after year. How many children will be born then?]
> (Participant 1: 38 years old, urban Bangalore, India, illiterate)

Definition of situation for induced abortion: majboori--baddhota (compulsion)

Induced abortion is clearly forbidden according to Islam but it is justified in a situation, which the women term as *majboori* (compulsion in Dhakani) and *baddhota* (compulsion in Bangla). *Majboori/baddhota,* that is, lack of options or a compulsion, is mentioned as the reason for undergoing an induced abortion. By citing "compulsion" as the reason for undergoing an induced abortion, the women in India and Bangladesh consider it a sufficient defence for the action. While defining

'compulsion', women stated that the reason for not having an additional child was because they already had a small child. Another reason cited was economic inability to support an additional child. From the woman's point of view, the prime concern is to ensure a good upbringing for the already surviving offspring. Having a small family is the way to achieve that.

> [I: Why do people get it done (induced abortion)?
> R: People get it done because they feel forced to do so. If you have many children and then it happens again, then it leads to difficulties.
> I: Do you know someone who has got it done?
> R: I do not know about others but I have got it done.
> I: When did you get it done?
> R: After I had two children, my youngest child was one year old. I was breast-feeding my child and then I got pregnant. I said that I did not want it. I cannot manage. Then I went with my brother's wife and got it done.
> I: You say that it is not right?
> R: It is not right but out of *majboori*, there is no one to help out.]
> (Participant 1: 38 years old, urban Bangalore, India, illiterate)

> [I: Do you know someone who has undergone MR (menstrual regulation)?
> R: MR is not seen in good light socially as well as religiously. However, many get it done out of *baddhota*. It is not possible to have many children. If one child is small and by accident if another comes (conceives again) then many a time it (induced abortion) is done.]
> (Participant 3: 31 years old, rural Matlab, Bangladesh, 12 years of education)

Justification for using contraception and induced abortion

According to the women in India and Bangladesh, Islam prohibits the use of contraception, specifically sterilisation. However, in planning their family they use both temporary and terminal methods. Specifically, one Indian woman reasons that by using temporary methods there is a chance of conception in future while sterilisation results in a permanent solution.

[I: If you have to stop after attaining the desired number of children, what can be done?
R: Then one should have the operation immediately. Whatever is done (contraception) after some time children are born but by having the operation childbearing can be stopped permanently. My mother-in-law tells me that whatever happens I should get operated (after having the second child).]
(Participant 2: 25 years old, urban Bangalore, India, 5 years of education)

It has been observed that only Bangladeshi Muslim women tend to give religious justification for the use of temporary methods of contraception as well as induced abortion. This reveals greater awareness of religious justification on their part with regard to reproductive matters. Though women have been using contraception and induced abortion there is still an awareness of performing an act of sin because it is not approved according to religious norms. In order to counter this sin, Muslim women in Bangladesh justify the use of temporary methods of contraception which averts a greater sin as in case of using sterilisation method. Some women in Bangladesh have also justified induced abortion as less sinful when it is performed within 45 days of conception because the foetus is not considered to be fully formed.

[I: Have you heard about ligation (sterilisation in Bangladesh)?
R: Yes. That is an even bigger *gunah* (than temporary). It has been seen to last for life and that childbearing can no longer take place. However, in using the pill though it means stopping temporarily there is still a possibility (for future childbearing) and that might lead to some forgiveness of *gunah* (sin). But using ligation puts a permanent stop to childbirth.]
(Participant 3: 31 years old, rural Matlab, Bangladesh, 12 years of education)

[I: If you get it done (within 45 days of conception) what happens?
R: It is wrong to get MR done but if it is done within 45 days then from the religious point of view there is forgiveness. After a mother gives birth and she does not do *namaaz* for 45 days, Allah does not write her name in the book of *gunah* (sin). The period of 45 days is treated similarly as the impure time during menstruation. If it (induced abortion) is done then there is no problem.]

(Participant 3: 31 years old, rural Matlab-Bangladesh, 12 years of education)

[I: What is your opinion about MR?
R: MR is a *gunah* (sin) but the *huzoors* say that in three to four months, Allah has "given everything" (foetus is well formed). But between one and a half months, it is almost like a blob of blood. It has not yet become a child.
I: Then in that condition can it (induced abortion) be done?
R: Yes, that is possible. But if it is three to four months old and it is done then it might even lead to death of the woman.]
(Participant 6: 34 years old, urban Dhaka, Bangladesh, 5 years of education)

7.6 Conclusions

The building blocks described earlier constitute the macro normative and micro negotiation orders which have been derived through grounded theory analysis. Together they enable us to construct an induced theoretical framework. The theoretical framework further elaborates on the process through which Muslim women in India and Bangladesh negotiate the normative religious order in order to realise their reproductive aspirations. This induced theoretical framework of India is depicted in Figure 7.1 and Bangladesh in figure 7.2.

Insert Figure 7.1 and 7.2 here

The normative order in Figures 7.1 and 7.2 refers to the religious dictums in matters of reproduction, which exist in the "memory traces" (Giddens 1984) of people. In the Indian and Bangladeshi cases, the normative order informs the women regarding Islam's stand on reproductive matters specifically the use of contraception and induced abortion. According to the interviewed women, Islamic dictums espouse the control of human agency by emphasising that all human beings and bodies are created by Allah and, thus any use of human volition to affect the functioning of human organ (uterus) through the use of contraceptives and induced abortion is prohibited.

Further, figure 7.1 reveals that religious sanctions are typical of the Indian context which are imposed on those women who undergo sterilisation. This is because sterilisation is the main method of contraception that is available in India. However, since Islam is opposed to the use of sterilisation, religious sanction is imposed on the adherents of Islam in order to discourage such violations. Those who transgress the religious prescriptions, as women indicate, are barred from performing religious duties and practices. These religious sanction against the use of sterilisation is possibly the result of the pro-sterilisation stand of the Indian family planning programme and instances of coercive sterilisation campaigns in the past (Iyer and Jesani 1999). Since sterilisation, the focus of the family planning programme in India, is against the dictates of Islam, the sanctions ensure conformity by creating an element of fear that the transgressors are likely to be punished with hell or by prohibiting the performance of religious rites and duties. Further, considering the fact that Muslims are a religious minority in India, Jeffery and Jeffery (1997) argue that these religious sanctions might also be a means through which the Muslims in India maintain distance from the pro-sterilisation family planning programme which symbolises the ideology of the majority Hindu population.

However, the knowledge of these religious norms and sanctions in matters of reproduction do not deter Muslim women in India and Bangladesh from exercising their agency. Those who are "knowledgeable" (Giddens 1984) about the religious norms exercise agency through the re-interpretation of these norms. Women re-define the applicability of the norms to their own life situation, by situating the normative order in the context of the older generation (time) and their present socio-economic situation (space). A few women are able to re-interpret the Islamic viewpoint through their first-hand exposure to the Quran. Through re-interpretations, women consider induced abortion as inappropriate, not only from the perspective of a child's right to life but also from that of the woman's health. According to their re-interpretation, the use of contraception is legitimate because it averts the possibility of an induced abortion. These interpretations allow women to use discretion in the matter of

reproduction by considering it as a personal matter. However, the process of reproductive decision making is not straightforward. The woman often finds herself torn between religious normative expectations and her individual reproductive aspirations. However, she often makes her choice in the best interests of her family, even at the risk of transgressing the religious norms of reproduction.

The negotiation of a woman's reproductive aspiration leads to the contestation of the dominant religious norms, which not only signifies the woman's agency but also her capacity to modify the norms (Giddens 1984; Tucker 1998).

The Muslim women in India and Bangladesh are not passive followers of norms but active actors who transgress the normative order in reproductive matters and take an active role in planning their families. Women utilise discursive reasoning through a definition of the situation and the conditions under which the transgressions occur. This reasoning is the means for attaining ontological security (Giddens 1991). In order to justify the act of transgression and also to mitigate the blame or guilt, women cite the lack of economic resources (allocative resources) (Giddens 1984) as the reason for planning their family size. Women in India and Bangladesh rationalise the reason for undergoing induced abortion through their life situation such as conceiving an additional child while the previous child is young or economic constraints. The rationalisation of induced abortion is expressed through *majboori/baddhota*, which implies that although their religious conscience forbade the act; however, they were compelled to do it. In both countries, the women have shown their appreciation for people who have small families and consider them to be "intelligent" or "people who have understood".

The difference in the Indian and Bangladeshi contexts has given rise to different context-specific strategies developed by the Muslim women in the two countries in order to realise their reproductive aspiration. For instance, the supply of sterilisation as *the* method of contraception propagated by the family planning programme of India has resulted in the imposition of religious sanctions on Indian Muslim couples who

undergo sterilisation. Further, the Indian Muslim women face relatively greater opposition from their immediate family members in matters of sterilisation and induced abortion. However, the Muslim women exercise agency by secretly undergoing sterilisation or induced abortion. They use the religiously proscribed methods without the knowledge of opposing family members.

In the Bangladeshi context, the Muslim women negotiate their reproductive aspiration by providing religion-based justifications for the use of contraceptives and induced abortion (Figure 7.2). Bangladeshi women are more knowledgeable about religion-based justifications, through which they are liable to commit relatively less sin - even though they transgress the norms. This knowledge of religion-based justification probably results from greater exposure to religious leaders who are trained in a liberal interpretation of Islamic principles with regard to reproduction (see chapter 6 for more). These women tend to justify the use of spacing methods as religiously more permissible than sterilisation because it stops childbearing only temporarily and leaves open the option of future childbearing. The Bangladeshi women are also aware of the religiously permissible condition for induced abortion, i.e. 45 days after conception. Induced abortion - though proscribed by Islam - is considered to be a lesser sin if conducted within 45 days of conception. These Bangladeshi Muslim women who seem to be more informed about the Islamic justifications primarily through flexible interpretation face fewer hurdles in realising their reproductive aspirations.

Figure 7.1: Summary of the induced theoretical framework, India

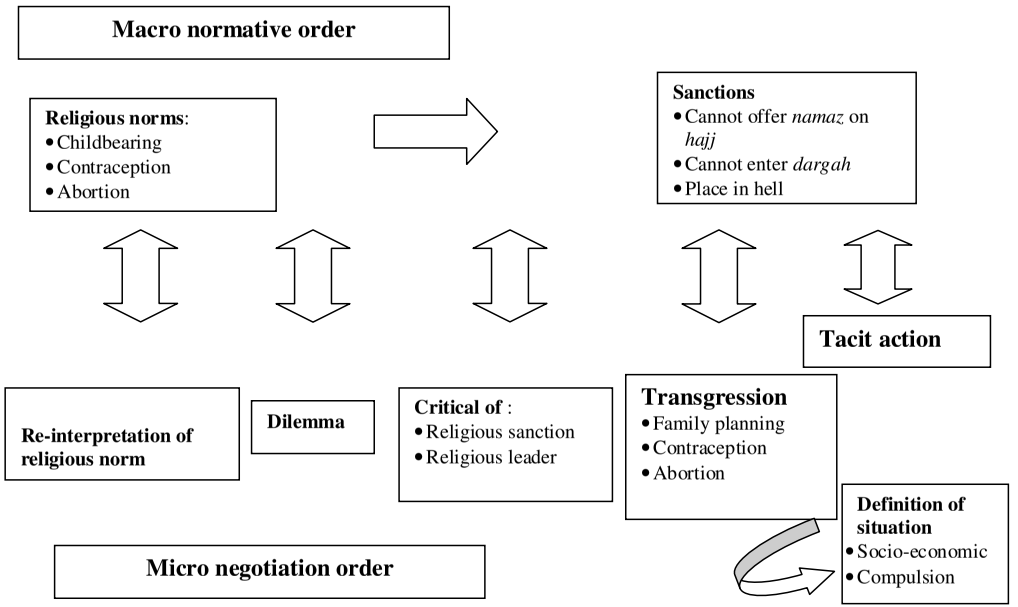
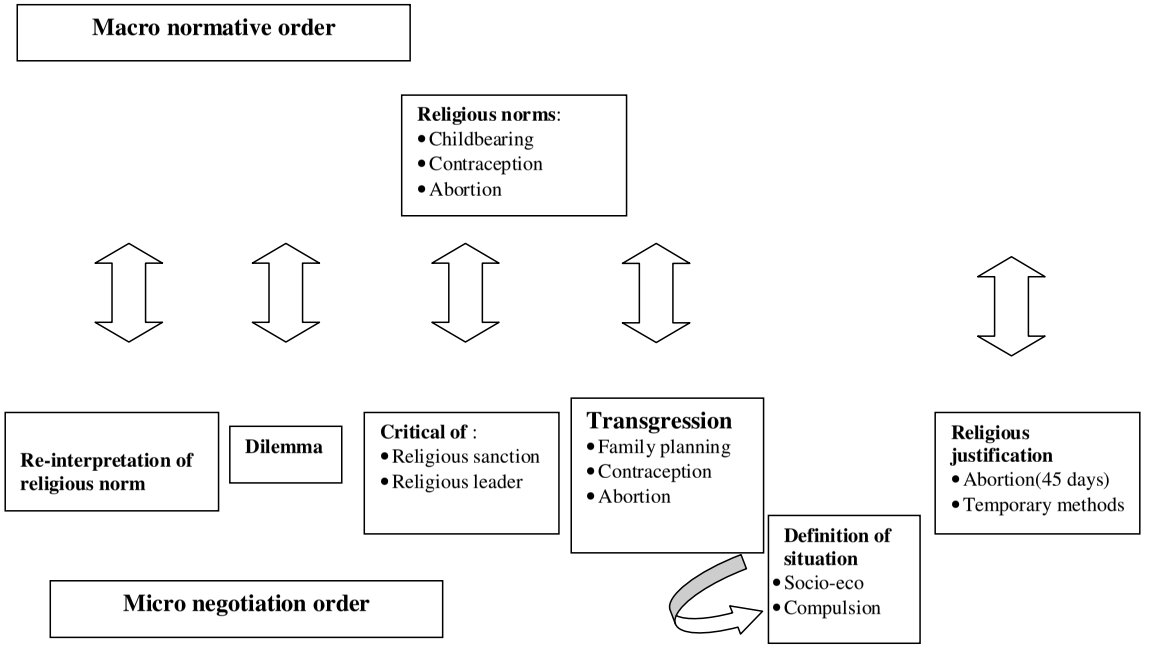


Figure 7.2: Summary of the induced theoretical framework, Bangladesh



Chapter 8: Conclusion and recommendation

8.1 Introduction

Religion influences several facets of human existence, reproductive behaviour being a prime one among others. Though it is not possible to attribute a coherent fertility pattern to a religious group, often Muslims tend to get labelled as pro-natalists. The reason for such generalisation can partly be attributed to Islamic rules that restrict the use of sterilisation and induced abortion (Shaikh 2003; Keefe 2006). However, attributing Islamic rules to be the sole route through which Muslim fertility level can be explained is a deterministic approach. The current research explores the other routes of understanding fertility of religious groups such as minority status, religiosity and agency. The general research objective of the current research is outlined as follows:

The present research adopts a comparative approach linked to the research questions that seek to explore the role of religion, minority status and agency on reproductive behaviour in India and Bangladesh.

8.2 What is the effect of religious minority status on fertility at the cross-country level of India and Bangladesh and at the intra-country level of India?

The empirical results from the district-level analysis of India (census data) reveal that the effect of concentration index is negative for the fertility level of both Hindus and Muslims. The negative sign of the concentration index supports the minority

hypothesis: the smaller the share of the religious groups in the total population of the district, the higher the TFR. The results further contend that the negative relationship between minority status and fertility is not confined to one religion i.e. Muslims (0.05 level) but that it is also relatively stronger for the Hindus (0.01 level).

The high fertility of Muslim religious minorities at the district level, this study interprets is a result of the socio-economic disadvantage experienced by Muslims minorities in India. The concentrated residential pockets (CRPs) where Muslims reside lack adequate socio-economic infrastructural provision. The inadequacy of socio-economic infrastructure such as health services, educational institutions and communication in the "Muslim space" restricts the utilisation of such services by the Muslims. It is a known fact that deficient socio-economic infrastructure has a profound impact on reproductive behaviour. For instance, education plays a crucial role in the formulation of notions regarding the size of family. Further, it also is a source of correct information regarding reproductive behaviour, specifically family planning practices. Hence, the dearth of educational institutions in the "Muslim space" blocks the possibilities that education might offer to influence people's perception regarding reproductive behaviour. Additionally, the absence of health facilities in the "Muslim space" restricts the dissemination of right information regarding contraception to the Muslims. It also limits the supply of contraception. Hence, such socio-economic disadvantages of the "Muslim space" do not constitute a conducive setting for Muslims to make informed reproductive choices. This study interprets this infrastructural disadvantage to be the reason behind the high fertility of Muslim minorities in India. Further, the district where Hindus are in the minority or in other words the district in which Muslims constitute the majority tends to be infra-structurally neglected (GOI 2006). Hence, we interpret that Hindus who reside in the Muslim majority districts also suffer from the same inadequate socio-economic infrastructure as the Muslims in that area. This could possibly explain the reason behind the relatively stronger impact of Hindu minority status on the fertility level of Hindus at the district level. Hence, higher fertility experienced by religious minorities

in India can be treated as two sides of the same coin i.e. socio-economic disadvantage experienced by Muslims in India.

8.3 What is the effect of religion in explaining fertility of Hindus and Muslims in India and Bangladesh?

This research measures religion in two different ways: religious group affiliation and religiosity. The latter is measured through a so-called religiosity index consisting of locally relevant religious indicators, for both religions. Those who are more religious were assumed to be those who are more likely to abide by religious rules of reproduction. This assumption was not supported by empirical findings because individual religiosity did not explain transition between parities (1-2 and 2-3) in India as well as Bangladesh. Further, despite being co-religionists, Indian Muslims follow a high fertility trajectory compared to Muslims in Bangladesh. The study argues that religious principles of Islam are not the sole route through which fertility behaviour of Muslims can be explained. In summary, the testing of the two measures of religion (*particularistic theology* hypothesis) with the fertility outcome has not yielded conclusive results. Thus, the *particularistic theology* hypothesis is rejected because both the measures of religion failed to garner empirical support for its linkage with fertility behaviour.

A possible explanation for the differential Muslim fertility could be attributed to a difference in the use of contraceptive methods by Muslims in India and Bangladesh. Muslims seem to favour temporary over terminal methods in both countries. However, Muslims in India tend to use the sterilisation method along with temporary methods whereas Muslims in Bangladesh use only temporary methods of contraception. Further Muslims in India are less inclined to use the sterilisation method than Hindus in India. Then what remains unanswered is why Muslims in India use sterilisation when they do not favour its use. This study argues that the use of sterilisation by the Muslims of India -despite the fact that they are less inclined to use it- is the missing link to the puzzle of the higher fertility trajectory of Muslims in India.

8.4 What can be learned from a comparison of Muslim reproductive behaviour in India with that of Bangladesh?

By comparing the situation in the two countries, the study concludes that the high fertility trajectory of Muslims in India is due to the heightened level of constraint that is experienced by the Muslims in India as compared to the Muslims in Bangladesh. These constraints can broadly be categorised into: characteristics of the family planning programmes (different methods propagated), the reaction of the community to this programme (sanctions), power relations in the family and characteristics of the community itself (language, concentrated residential pockets).

The Indian family planning programme has primarily focused on sterilisation, which is disapproved by Islamic principles. Hence, Muslim couples in India are constrained because the sterilisation method - an Islamic-proscribed method of contraception is supplied by the Indian family planning programme. By comparison, Muslim couples in Bangladesh are not constrained because the Bangladeshi family planning programme primarily focuses on temporary methods of contraception - an Islamic-approved method of contraception. The study further contends that the programmatic thrust on sterilisation in India and temporary methods in Bangladesh is not mere coincidence. Hinduism which is also the religion of the majority is not opposed to any specific method of contraception. In light of the Hindu religious fervour, the Indian family planning programme has adopted sterilisation as the main method of contraception. On the other hand, Islam - the state religion of Bangladesh - focuses on temporary methods. Hence, the family planning programmes are designed according to the majority community's religious affiliation. However, this results in a constraining situation for the Muslims to adopt contraceptives in India as compared to the Muslims of Bangladesh.

Further, the Indian Muslim couples who undergo sterilisation face additional hurdles through the imposition of religious sanctions because sterilisation runs counter to the

Islamic dictums. The unequal power relation based on gender and generational differences serves as the medium through which the family exercises social control on the young couples who may be inclined to use Islamic-proscribed method, sterilisation. Additionally, the Indian Muslims in Karnataka, India, have a distinct linguistic identity (Dhakani) and they live in concentrated residential pockets. This isolates the Muslims in Karnataka, specifically women, and restricts them from any contact with the majority community. It is reasonable to assume that this lack of inter-community interaction obstructs avenues for diffusion of information regarding reproductive matters. Additionally, the residential segregation has also resulted in the socio-economic infrastructural neglect of the areas in which the Muslims reside. The Muslims of Bangladesh do not suffer from any such hurdle in using contraception at the community or family level. The common language Bangla binds the Muslims and Hindus of Bangladesh together. There is no residential segregation observed among Muslims in Bangladesh. Hence, the higher fertility trajectories of the Indian Muslims might be a result of a far greater hurdle faced by them vis-à-vis the Muslims of Bangladesh in realising their reproductive aspirations. From the foregoing discussion it is concluded that religion influences fertility level; however, its role assumes different forms based on the context in which it is situated.

8.5 How do women negotiate Islam in order to realise their reproductive aspiration in the cross-country context of India and Bangladesh?

Based on the induced theoretical framework, it is concluded that women are not passive followers of religious norms but active actors who transgress the normative order in reproductive matters and take an active role in planning their families. In this, they utilise discursive reasoning through a definition of the situation and the conditions under which the transgressions occur. This reasoning is the means for attaining ontological security (Giddens 1991) to justify the action in order to mitigate the blame or guilt.

The difference in the Indian and Bangladeshi contexts has given rise to different context-specific strategies developed by the Muslim women in the two countries in order to realise their reproductive aspirations. For instance, the supply of sterilisation as *the* method of contraception by the family planning programme of India and the Islamic restriction on the same have resulted in the imposition of religious sanctions on Muslim couples who undergo sterilisation. Further, the Indian Muslim women face relatively greater opposition from their immediate family members when they resort to sterilisation and induced abortion. However, the Muslim women exercise agency by maintaining silence over the act (contraception or abortion). They make use of the religiously proscribed methods (sterilisation or induced abortion) without the knowledge of family members who oppose the use of such methods.

In the Bangladesh context, the Muslim women negotiate their reproductive aspirations by providing religion-based justifications for the use of contraceptives and induced abortion. Bangladeshi women are more knowledgeable regarding the religion-based justifications through which they are liable to commit a relatively lesser sin - even though they transgress the norms. Hence, they are less constrained in realising their reproductive aspirations. This knowledge of religion-based justifications probably results from greater exposure to religious leaders who are trained in liberal interpretation of Islamic principles with regard to reproduction.

Based on the empirical findings of the current research, it is concluded that there is no general trend in Muslim fertility that can be distinguished in India and Bangladesh. Religious rules play an important role not only in the lives of individuals but also in the design of the family planning programmes. Further, the community plays an important role in maintaining conformity with religious rules of reproduction. They plan the size of their family taking their best interests into account. However, people do not blindly follow religious rules that dictate reproductive behaviour.

In summary, the empirical findings of the study prove that the generalisation regarding pro-natality of Muslim fertility is often exaggerated. Religion does play an important role in reproductive behaviour of its adherents; however, the influence and ramification of religion is often contextually determined (e.g. majority or minority status, socio-economic status etc). To sum up, irrespective of religion, if a conducive atmosphere is provided, people plan their reproductive behaviour in the best interest of their family. The study concludes that with regard to reproduction, people prioritise quality (education, standard of living) of a child's upbringing over quantity.

8.6 Mixed methods in comparative research

A mixed-method research design has been adopted by the current research. The methodology chapter (chapter 2) discusses the phase-wise manner (quantitative-qualitative-quantitative) in which the methods are employed. The method used in each phase complements the subsequent phases. For instance, complete coverage (first phase) furnished baseline information for the qualitative data collection (second phase) and survey (third phase) data collection. Further, the participants of the qualitative interviews (second phase) were selected based on complete coverage data (first phase). Additionally, inputs from qualitative data (second phase) were used to contextualise the survey instrument (third phase). Finally, the sample for the survey phase (third phase) was drawn from the baseline data collected through complete coverage (first phase).

The comparative nature of the research posed several challenges and the strategies that were used to resolve the challenges are elaborated in the methodology chapter. For instance, in order to train the two multi-lingual research teams (Hindi in India and Bangla in Bangladesh) different strategies were used. Further, in order to ensure standardisation in the training, the same training techniques were applied to the two research teams. The chapter also elaborates the contextualisation of the research instrument in each research location by incorporating local variations based on religious practices, languages and countries. The methodology chapter also reflects on

the lessons that were learnt with regard to data management. These methodological issues of the current research can serve as a reference point for other researchers seeking to conduct comparative research along similar lines.

8.7 Researcher's positionality

The present research reflects on the interaction between the researcher's personal identity and that of the participant. Reflexivity regarding self-other negotiation is necessary because it forms a crucial aspect of face-to-face interaction which is characteristic of qualitative data collection. The chapter also stresses the need to think through the strategies of representation in the field at the conceptual phase of the research.

8.8 Approach to the study of fertility among religious groups

There is a certain sensitivity that is attached to the demographics of religious groups. This sensitivity arises due to mis-interpretation of the demographic figures of religious groups. For instance, the growth rate of Muslims (religious minority in India) has been "misconstrued" as resulting in outnumbering the dominant religious community (Hindus). Further, the higher fertility of Muslims in some contexts has resulted in Islam being labelled as "pro-natalistic" in the popular discourse (South Asia and rest of the world).

The current study is aware of the possible interpretation/mis-interpretations of the results that can be drawn while analysing the demographics of religious groups and hence clarifies its stand as one that is purely academic in nature. The current research has tried to understand the reason behind the differential fertility level of Muslims as opposed to Hindus (inter-country and intra-country) through various routes of explanation. The present comparative study has been designed to understand the possible links of a missing demographic puzzle i.e. Muslims exhibiting different fertility levels in the Indian and Bangladeshi contexts. Further, based on contextually-embedded empirical insights the current study suggests correctional measures that can

be adopted by policy planners as well as the community to overcome the hurdles in realising aspired family size. Hence, the examination of the fertility differentials and the reasoning provided in this book should not be generalised and should be interpreted in the light of the research context.

8.9 Suggestions and Recommendation

Based on the conclusions drawn from the current research, the study suggests scope for future research and discusses policy recommendations as follows.

Scope for future research

The study argues that infrastructural amenities play an important role in determining fertility differentials of religious minority groups. The empirical relationship between the distribution of infrastructural facilities of areas inhabited by religious minority groups and its subsequent influence on fertility levels should be empirically tested. In the absence of such information, this study recommends collection of such information at the micro level.

Based on qualitative information the current research stresses the pivotal role that the community and the family play in determining the course of reproductive lives of young couples. The family and the community is the medium through which cultural values (religion, gender, inter-generational) are internalised and sustained. Hence, there arises a need to explore the role of the community and the family with micro data in order to ascertain their true role in reproductive decisions.

Finally, the current research has argued that language plays an important role for the diffusion of reproductive health information. The current research stresses the need to examine the role of language rigorously in explaining the acceptance of family planning practices among religious groups with the aid of micro-level data.

Policy recommendations

As observed in chapter 4, it is clear that there is a need to ensure that Muslim minorities in India enjoy similar socio-economic and infrastructural facilities as the religious majority community in India. The social and physical infrastructural

facilities such as educational institutions, medical facilities, post and telegraph facilities, bus services and durable road are needed by all religious communities and these should be provided in an equitable manner. This is essential because socio-economic factors have an important bearing on the fertility outcome of the religious communities.

Furthermore, the distinct Muslim residential settlements (CRPs) in India face many negative repercussions which result in the isolation of the community from the mainstream population as well as in the infrastructural neglect of such areas. Thus, there is a need to address the root problem which has created such settlement i.e. insecurity arising out of communal conflict (GOI 2006). The insecurity has resulted in the shrinking of common communal space, according to Jha (2009). A solution to this problem could be achieved through the enhancement of inter-community accommodation and strengthening of shared spaces and shared interests. Community organisations can play a crucial role in demystifying the mistrust and stereotypes attached to community identities. In these common spaces a dialogue between the communities, for instance between Hindus and Muslims, is required and there is a need to acknowledge the past communal antagonism and mistrust between the two communities while at the same time there is a need to work out solutions by adopting a forward-looking approach in order to strengthen reconciliation (Jha 2009).

Female sterilisation has been the main method propagated by the Indian family planning programme since its inception (Pachauri 2004). In 1996 the Indian family planning programme has undergone a paradigm shift (GOI 2000), from a target-oriented approach to a client-centred approach. This client-centred approach is committed towards providing information as well as to making available varied contraceptive choices (including spacing methods) to people. However, it is observed that even though the shift has taken place at the policy level, the change is still to be implemented in practice (Visaria et al. 1999; Pachauri 2004). Chapter 6 reveals that the pro-sterilisation stand of the Indian family planning programme has created

hurdles for Muslims to accept sterilisation since it runs counter to their Islamic religious beliefs. There is a need to ensure that the policy-level change (providing wider contraceptive choices) is implemented in practice. Specifically, if temporary contraceptive methods are available to the Muslim women in India, it will overcome the religion-based hurdle that Muslim women face in using contraception.

Most of the Muslim women in urban Karnataka, India, can speak only one language i.e. Dhakani. Hence, the health care providers need to be linguistically competent to communicate in a language which is mutually understandable. If the health care providers could speak Hindi, which is understood by Muslims, it could easily solve the linguistic barrier between the health care provider and the client. Additionally, owing to the inter-group dynamics in India, the study recommends recruitment of Muslim health personnel in Muslim CRPs which the study assumes will enhance the sense of solidarity between the client and the provider of health services.

In India the NPP-2000 has included religious leaders in the family planning draft policy, indicating that the policy planners recognise the potential positive role that religious leaders can play in the family planning programme. However, a concrete plan of action has not been executed so that the religious leaders are brought into the domain of reproductive health. The *imam* (Muslim religious leaders) training programme of Bangladesh could serve as an example for the Indian family planning programme. In Bangladesh, the religious leaders have played a positive role as facilitators of change in the field of reproductive health. Based on the Bangladeshi example the study hypothesises that similar training of *imams* in India could exert a positive impact in reforming the religious notions about reproduction. The religious leaders who are trained in liberal interpretations of Islam can play a crucial role in demystifying religious sanctions that are prevalent among Muslims in India.

Furthermore, the distinct Muslim residential settlements (CRPs) in India face many negative repercussions because they result in the isolation of the community from the mainstream population as well as in the infrastructural neglect of such areas. Thus,

there is a need to address the root problem which has created such settlement i.e. insecurity arising out of communal conflict (GOI 2006). The insecurity has resulted in the shrinking of common communal space, according to Jha (2009). A solution to this problem could be achieved through the enhancement of inter-community accommodation and strengthening of shared spaces and shared interests. Community organisations can play a crucial role in demystifying the mistrust and stereotypes attached to community identities. In these common spaces a dialogue between the communities, for instance between Hindus and Muslims, is required and there is a need to acknowledge the past communal antagonism and mistrust between the two communities while at the same time there is need to work out solutions by adopting a forward-looking approach in order to strengthen reconciliation (Jha 2009).

Female sterilisation has been the main method propagated by the Indian family planning programme since its inception (Pachauri 2004). In 1996 the Indian family planning programme has undergone a paradigm shift (GOI 2000), from a target-oriented approach to a client-centred approach. This client-centred approach is committed towards providing information as well as to making available varied contraceptive choices (including spacing methods) to people. However, it is observed that even though the shift has taken place at the policy level, the change is still to be implemented in practice (Visaria et al. 1999; Pachauri 2004). Chapter 6 reveals that the pro-sterilisation stand of the Indian family planning programme has created hurdle for Muslims to accept sterilisation since it runs counter to their Islamic religious beliefs. There is a need to ensure that the policy-level change (providing wider contraceptive choices) is implemented in practice. Specifically, if temporary contraceptive methods are available to the Muslim women in India, it will ease the religion-based hurdle that Muslim women face in using contraception.

Most of the Muslim women in urban Karnataka, India, can speak only one language i.e. Dhakani. Hence, the health care providers need to be linguistically competent to communicate in a language which is mutually understandable. If the health care

providers could speak Hindi, which is understandable to Muslims, it could easily solve the linguistic barrier between the health care provider and the client. Additionally, owing to the inter-group dynamics in India, the study recommends recruitment of Muslim health personnel in Muslim CRPs which the study assume will enhance the sense of solidarity between the client and the provider of health services.

In India the NPP-2000 has included religious leaders in the family planning draft policy, indicating that the policy planners recognise the potential positive role that religious leaders can play in the family planning programme. However, a concrete plan of action has not been executed so that the religious leaders are brought into the realm of reproductive health. The *imam* (Muslim religious leaders) training programme of Bangladesh could serve as an example for the Indian family planning programme. In Bangladesh, the religious leaders have played a positive role as facilitators of change in the field of reproductive health. Based on the Bangladeshi example the study hypothesize that if similar training of *imams* can be conducted in India, it could have positive impact in reforming the religious notions about reproduction. The religious leaders who are trained in liberal interpretations of Islam can play a crucial role in demystifying religious sanctions that are prevalent among Muslims in India.

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Appendix A: Written consent form for participants of the research in Bangladesh

Protocol Number: _____

Title of Project: Religion, minority status and reproductive behaviour among Muslims and Hindus in India and Bangladesh

Principal Investigator's name: Ms. Biswamitra Sahu

Before recruiting into the study, the respondent must be informed about the objectives, procedures, and potential benefits and risks involved in the study. Details of all procedures must be provided including their risks, utility, duration, frequencies, and severity. All questions of the respondent must be answered to his/her satisfaction, indicating that the participation is purely voluntary. The respondent must indicate his/her acceptance of participation by signing or thumb printing on this form.

I am ……..and I work at the ICDDR, B: Centre for Health and Population Research, Dhaka, Bangladesh, under the programme entitled "Religion, minority status and reproductive behaviour of Muslims and Hindus in India and Bangladesh"

Purpose of the research

This study aims to understand why some women have more children than others. We would like to know whether religious beliefs shape women's perception of ideal family size and acceptance of contraception.

Why selected

In this study we will interview currently married women in the age group of 18 to 44 years. You fulfil this criterion as most of you have had/are going to have children. Your experience will help us learn regarding religious perceptions and practices revolving around fertility and child care. This knowledge will help us advise population policy planners devise interventions in this field, keeping in mind your values and beliefs. This is why we invite you to participate in this interview.

Procedure

If you accept, you will be invited to answer some questions. This interview will be conducted by me ……The interview will be conducted in a place convenient to you and preferably no one else will be present during the interview (if you so wish). The interviews will be recorded with the help of a voice recorder. This will be done to ensure that no valuable data is lost during interview. Thus we seek your permission to record the interview. Recorded information is considered confidential and no one else other than the investigators of the research project will have access to the records. The expected duration of the interview will be around 60 minutes.

Risk

During the interview you might feel uncomfortable while answering some questions which are personal in nature. If such a situation should arise and if you feel uncomfortable you may refuse to answer such questions.

Benefits

You will not receive any direct benefit from your participation in this study; however, the results of this study would improve our knowledge regarding fertility and thus, improve our understanding about disparities in reproductive health outcomes based on religious beliefs and practices.

Incentives

You will not receive any incentive for taking part in the research.

Privacy, anonymity and confidentiality

We do hereby affirm that privacy, anonymity and confidentiality of data/information identifying you as participant will be strictly maintained. However, any personal identifiable information will be held and processed under secured conditions, with access confined to investigators of the research project. Dissemination of the results will be done after the data have been analysed and conclusions drawn.

Right not to participate or to withdraw

Your participation in the study is voluntary, and you are the sole authority to decide on or against your participation in this study. You would also be able to withdraw your participation any time during the study. Refusal to take part in or withdrawal from the study will involve no penalty.

Who to contact

This proposal has been reviewed and approved by Research Review Committee and Ethical Review Committee at ICDDR, B, whose task is to make sure that research participants are protected from harm.

If you have any questions you may ask them now or later. If you wish to ask questions later, you may contact any of the following: Ms Biswamitra Sahu, Health and Demographic Surveillance Unit (HDSU), Public Health Science Division ICDDR, B, Mohakhali, Dhaka1212, Bangladesh.

Please indicate your agreement by signing or leaving your left thumb print in the designated space below.

Thank you for your cooperation.

I have read the forgoing information/ the foregoing information has been read to me. I have had the opportunity to ask questions and any question I have asked has been answered to my satisfaction. I consent voluntarily to participate in the study and understand that I have the right to withdraw from the interview at any time without in any way affecting my family and me.

_____ _____

Signature or left thumb impression of respondent Date

_____ _____

Signature or left thumb impression of the witness Date

_____ _____

Signature of the PI or his/her representative Date

(NOTE: In the case of a representative of the PI, she/he shall state her/his full name and designation and then sign)

Appendix B: Female Interview Guidelines

Religion, minority status and reproductive behaviour among Muslims and Hindus in India and Bangladesh.

Introduction

This study tries to explore the linkages of identity such as religion, minority status and gender on the decision-making processes among Hindus and Muslims in India and Bangladesh. The guide is designed to help the interviewer to ascertain whether the interview has covered all points required for the study.

1. Background factors

- Age
- Education
- Marital Status
- Religion
- If Hindu- Caste and sub-caste
- If Muslim- type (Sayeed, Sheikh, Moghul, Pathan)
- Occupation
- Kind of occupation

2.1 Context of marriage

Among your people, at what age are girls expected to get married? At the moment are young people getting married according to the consent of their parents or their own choice of partner, and which was it in your case? What are the attributes in a prospective groom and the background that determines the chances of getting married? Now tell me more about the circumstances under which you got married starting from the point the proposal came in till the time the marriage ceremony commenced.

1. Beliefs and attitude regarding marriage.

Probe:

a) Role of marriage in a society.
b) Government prescribed age of marriage for boys and girls.
c) Age at marriage of self and husband.
d) Right age of getting married in your community.

2. Role of significant others in marriage negotiation.

Probe:

a) Role of your husband's/in-laws' characteristics in deciding age at marriage.
b) Kin Marriage.

3. Agency.

Probe:

a) Your say in matters related to marriage.
b) Consequence of denial to marriage proposal.

2.2 Pregnancy, delivery, nutrition and child care

1. Tell me about your last pregnancy/pregnancies?

Probe:

a) Age at the time of first pregnancy.
b) Age at the time of last pregnancy.
c) Source of practical information (diet, cleanliness, care to be taken, work to be done or avoided, do's and don'ts) during pregnancy.

d) Place of residence during pregnancy (maternal, in-laws etc.).
e) Ceremony or festival observed during pregnancy.
f) Regimen of physically strenuous/non-strenuous work during pregnancy.
g) Husband's role in taking care emotionally and sharing responsibilities at home and family matters.
h) State of mind (happy, cheerful, worried, tensed, anxious) during the pregnancy.

2. Tell me something about your delivery.

Probe

a) Place of delivery.
b) Type of delivery.
c) Gestation.
d) Single/twin birth.
e) Birth attendant.
f) Duration of ritual purity and pollution.
g) Site of delivery (usual bed/separate bed).
h) Sanitation of bedding (old/new).
i) Instrument used for cutting umbilical cord.
j) Weight of baby in kilograms.

3. Tell me something about the nutrition of the child as soon as it was born.

Probe:

a) How much time after your baby was born did you see and hold your baby?
b) When did you first breastfeed?
c) Food other than breast milk.
d) Baby's nutrition in first month of its life.
e) Ceremony marking the child's initiation to other kinds of food.

4. Tell me something about your nutrition during and after pregnancy.

Probe:

a) Difference in amount or the content of food from the usual food intake.
b) Advice given regarding your nutrition (food preferred, quantity).
c) Avoidance of some kinds of food during pregnancy.
d) Food after pregnancy and during breastfeeding.

2.3 <u>Context of contraception</u>

What is the right size of a family and the reason behind that? How to achieve that size? Need for birth interval between kids, what should be the duration?

Note: Question not to be asked to sterilised, menopausal and pregnant women

1. Beliefs and attitude regarding contraception (last time used).

Probe

1) What are the different methods of contraception and your reason for using contraception (space and limit)?
2) History of use of contraception? Last use of contraception, which method, duration of use and source.
3) Use of condom by husband.

Probe

a) Problem faced during use.

2. Norms regarding contraception and the role of significant others in determining use.

Probe:

a) Usual practice of contraception prevalent among the women you interact with and which ones do you find acceptable?
b) With whom do you discuss contraceptive methods and theirs use and their consequent influence on decisions?

c) Opinion of religion/religious leaders on contraception.

3. Role of agency in the use of contraception (last time).

Probe:

a) Ability to use contraception, from whom to seek permission.

2.4. <u>Context of induced abortion</u>

Have you heard about induced abortion and what reason would you attribute to it? Do you know someone who had an abortion and what was the reason? How did people react to it?

Note: If a woman has had induced abortion then ask her about her own experience, if not then ask about other woman's experience.

1. Beliefs and attitudes regarding induced abortion

Probe:

a) Own opinion regarding abortion.
b) Under what condition should it be performed?
c) Where to get an abortion done.

2. Role of significant others in matters of induced abortion.

Probe:

a) Perception of husband, family and your community.
b) Perception of religious leaders.

3. Role of agency in the matter of induced abortion.

Probe:

a) Would you consider having an induced abortion without discussion/permission with/from husband, in-laws, relatives etc.?

2.5. <u>Context of Breastfeeding</u>

When do people start breastfeeding their new ones and what is the duration? Does she have knowledge of linkage between breastfeeding with childbearing (contraception). What precautions to be taken by women who breastfeed.

1. Beliefs and attitude regarding breastfeeding (last time).

Probe:

a) Importance of breastfeeding.
b) Your experience of breastfeeding (when, duration).

2. Role of significant other in breast feeding.

a) In-laws', parents' or relative's advice regarding breastfeeding.

3. Role of agency in breastfeeding.

Probe

a) Agency exercised in breastfeeding child (duration of breastfeeding).
b) Role of husband/parents, in-laws.

3. <u>Religious Identity and Religiosity</u>

1. Religious faith of parents.
2. Religious atmosphere at home during childhood.

Probe:

a) Who introduced you to religious beliefs and practices?
b) What were the rituals which were expected to be followed on a daily basis during childhood?
c) Stories told by grandparents (religious epics/stories of saint)?

3. Religious rituals marking rites of passage.

Probes:

a) Name-giving ceremony by *pandit/maulvi*, after how many days of birth?
b) Tonsure (*mundan/hakika*).
c) For Muslims, reading of Arabic and reciting Koranic verses.

d) Puberty rites after menarche (telling relatives, rituals, feast).
e) Marriage solemnised through religious rites. What were those rites (*yajna, saptapadi, tali* for Hindus and *nikah nama* for Muslims)?

4. After marriage what were the visible changes about you?
   Probes
a) Clothing.
b) Food.
c) Symbol of marriage.
d) Code of conduct.

5. At present what are the religious practices that you follow?

Probes
a) Prayers (frequency).
b) Visiting temple/mosque (which days of the week).
c) Listening to religious sermons/*pravachans* for Hindus and *istama* for Muslims (if yes, frequency)
d) Reading holy text.
e) Watching religious TV shows.
f) Radio message.
g) Fasting (reason for it).
h) Symbols of religion (thread around neck and wrist, *taviz*, veil or *burkha*).
i) Making a wish (*mannat* for Muslims and *harke* for Hindus).

6. Why do you feel it is necessary to follow these rituals on a day-to-day basis?
7. What motivation/inspiration do you derive from your religion?
8. What is the role of religion in your life?
9. How do you interpret the philosophy of religion?
   Probe:
   a) Reading religious text.
   b) Religious leaders.
10. What are the views of religious leaders on family issues?

Probes:
   a) Children (how many).
   b) Contraception.
   c) Abortion.

11. Degree of commitment to the dictums of your religion.
12. Discussion of religious matters with husband, in-laws or friends and, if you do, which topics do you usually discuss?
14. In your opinion how should a good Hindu/Muslim woman behave towards husband, family members, in-laws, relatives etc.?
15. It usually happens that when people have some personal problem they resort to their religion through prayer or *mannat*. What is your experience in the same situation?
16. Expectations concerning children (son/daughter) tconducting some specific kind of rituals/prayers on a daily basis and its reason.
17. Do you play any role in the religious fairs that get organised in your village every year; what role do you play?

4. <u>Gender Dynamics</u>

1. What is your daily time schedule in and outside the house?
2. What according to you is a woman's position in the family and community?
3. What according to you are the factors that contribute to women's higher or lower status in the family and in the community?
4. What according to you are the factors that contribute to a man's higher or lower status in the family and in the community?
5. How would you define your status in your family?

Probe

a) Respect received from husband, family, in-laws etc.
b) Decision making (health, education of children etc.)
c) Ownership of assets.

6. Has there been a change in your status over time?

Probe:

a) Age.
b) Education.
c) Work status.
d) Marriage.
e) Motherhood.

7. Is your opinion sought when some decision is being made at home and in what way do you contribute to it?
8. When you do something which is not expected of you, how does your husband or in-laws react to it?
9. What according to you is the ideal sex composition of a family?
10. Is it better to have more sons or more daughters and why?

5. <u>Groups and Minority Identity</u>

1. What are the different religious groups in your locality?
2. Do women of these communities interact with each on a day-to-day basis?
3. Do you participate in each other's religious and social functions (occasions and in which way)?
4. Do you feel welcomed or part of the group which consists of people from the other religious community?
5. Is there any similarity between people of your religious community (Muslim/Hindu) and people of the other religious community (Muslim/Hindu)?
6. If yes, what are the similarities between people of your religious community (Muslim/Hindu) and people of the other religious communities (Muslim/Hindu) both visually (the way they dress up) and behaviourally (for example: interaction, way of conducting things)?
7. Is there any difference between people of your religious community (Muslim/Hindu) and people of the other religious community (Muslim/Hindu)?
8. If yes, what are the differences between people of your religious community (Muslim/Hindu) and people of the other religious community (Muslim/Hindu) both visually and (the way they dress up) and behaviourally (for example: interaction, way of conducting things)?
9. People from which community in your opinion are more represented in government posts?
10. People from which community in your view have greater economic resources and opportunities?
11. Who do you think dominates the political and economic situation between the two communities?

6. <u>Infant Mortality</u>

1. Why do young children die in the first few days, weeks or months of their birth? What do people do to deal with it?

7. <u>Sanitation and Hygiene</u>

a) Is there safe and purified water at your home for drinking?
b) Did you use boiled water for a few days or months after the child's birth?
c) Did your house have proper waste disposal?
d) What sort of diapers did you use for the baby?
e) How did you wash them and where?
f) After the child started drinking from a bowl or feeding bottle did you sterilize that with boiling water properly?

8. <u>Parent's knowledge and effective reaction to health problem</u>

a) Were you aware of the precautions that you should take while you were pregnant probably advised by doctor, nurses and health worker?
b) Did your husband come with you to the health centre when you had tetanus injections or collected IFA tablets?
c) Was he supportive towards you when you were in labour (consoling and comforting)?
d) Were you both aware that it is very important to take care of nutrition and hygiene of the child?
e) Did you seek the advice of a doctor when there were some complications in pregnancy?
f) When your child falls sick do you and your husband seek the doctor's advice immediately?

Appendix C: Male Interview Guideline

Religion, minority status and reproductive behaviour among Muslims and Hindus in India and Bangladesh.

Introduction

This study tries to explore the linkages of identity such as religion, minority status and gender on the decision-making processes among Hindus and Muslims in India and Bangladesh. The guide is designed to help the interviewer to ascertain whether the interview has covered all points required for the study.

1. Background

- Age.
- Can you read and write?
- Education (in years).
- Religion.
- If Hindu- caste and sub-caste
- If Muslim- type (Sayeed, Sheikh, Moghul, Pathan).
- Type of family.
- Language (family, others).
- Working status.
- Kind of occupation.

2.1 Context of marriage

Among your people, at what age do boys get married? What are the attributes (age, education, looks, and job) of a prospective bride that determine the chances of getting married? Now tell me more about the circumstances under which you got married starting from the point the proposal came in till the time the marriage ceremony commenced.

1. Beliefs and attitude regarding marriage.

a) Importance of marriage in a society.
b) Government prescribed age of marriage for boys and girls.
c) Your age at marriage and wife's age at marriage.
d) Do you think that it was the right age for you to get married and why?

2. Role of significant others in marriage negotiation.

Probe:

a) Role of parents and relatives in marriage.
b) Marriage among close relatives permissible or not and among whom.
c) Consent for marriage.
d) What was the role of your wife's/in-laws' background in determining your age of marriage
e) Was your marriage consummated soon after marriage or later, when?

2.2. Father's involvement during pregnancy, delivery, nutrition and child care

1. Fatherhood.

a) Who informed you that your wife is/was pregnant?
b) In which month of pregnancy were you informed?
c) What did you feel after knowing that you were soon going to be father?
d) What are the rituals that are followed when a woman gets pregnant and then immediately after birth?

2. Involvement in transition to fatherhood (if 1st time then projective).

Probe:

a) Did you consult a doctor/elders regarding what sort of care and precaution should be taken for your wife during her pregnancy, if yes what were they?
b) Did you visit the doctor for immunisation with your wife during her pregnancy?
c) Did you get IFA tablets for your wife during her pregnancy?
d) Did you take care that your wife to ate nutritious food during pregnancy?
e) Did you get her food that she wanted?
f) Did you help her with housework during pregnancy?
g) Did you restrict her from doing certain work or eating certain food which you thought might affect the child in the womb? If yes, what were they?
h) When she was about to deliver were you at home? If yes, did you take her to the doctor or fetch any traditional birth attendant to your home?
i) Were you present inside or outside the premises where she was delivering the baby? What was your role during that time?

3. Parents' knowledge and effective reaction to health problems.

a) Were you aware of the precautions that you should take while your wife was pregnant, which were probably advised by doctor, nurses and health worker?
b) Were you supportive (comforting, consoling or giving moral support) of your wife when she was in labour?
c) Were you aware that it's very important to take care of nutrition and hygiene of the child?
d) Did you seek the advice of a doctor when complications arose during your wife's pregnancy?
e) When the child gets ill do you and your wife seek the doctor's advice immediately? What else do you do to handle the situation? (Indigenous medicine)

2.3. Context of contraception

What is the right size of a family and the reason behind that? How to achieve that size? Need for birth interval between kids, what should be the duration?

1. Beliefs and attitude regarding contraception

Probe:

a) Reason for use of contraception (space and limit) and what are the different methods?
b) History of use of contraception by you/wife? Last use of contraception, which method, duration of use, source and problem faced if any.
c) Problem faced during use.
d) Do you take an active part in contraception use?
e) Discussion with wife regarding contraception.
f) Do you share responsibility of spacing children by using condoms?

2. Norms regarding contraception and the role of significant others in determining use.

Probe:

Probe:

a) Do men discuss contraception among themselves?
b) With whom (friends, relatives, elder brother etc.) do you discuss contraceptive methods and its use?
c) Does their opinion influence your decision?
d) What do religion/religious leaders think about contraception?
e) Does it influence your decision?

3. Role of agency in the use of contraception (last time).

Probe:

a) How much control do you have on the type of method to be used by you/your wife and when?

2.4. Context of induced abortion

Have you heard about induced abortion and what reason would you attribute to it? Do you know someone who had an abortion and what was the reason? How did people react to it?

Note: If wife has undergone induced abortion then ask him about her experience, if not then ask about other women.

1. Beliefs and attitude regarding induced abortion.

Probe:

a) Opinion regarding abortion.
b) Under what condition?
c) Where to go?
d) Would you advise your wife to undergo an induced abortion? Under what condition?

2. Role of significant others regarding induced abortion.

Probe:

c) Perception of wife, family and community.
d) Perception of religious leaders.

3. Role of agency regarding the use of induced abortion (Not applicable)

2.5. Context of Breastfeeding

For how long do women of your community breastfeed their new ones? Are you aware of the fact that when your wife is breastfeeding she has lower chances of getting pregnant? How did you come to know of this?

1. Beliefs and attitude regarding breastfeeding (last time).

Probe:

a) What is the importance of breastfeeding a child?
b) When did your wife breastfeed your child and for what duration? Was there any problem (shortage of milk)?

2. Role of significant others regarding breastfeeding.

a) Do your in-laws, parents or relative advise your wife on breastfeeding (duration, nutrition etc.) while she was breastfeeding?

3. Role of agency regarding breastfeeding (NA)

3. Religious Identity and Religiosity

6. Religious faith of parents.
7. Religious atmosphere at home in childhood.

Probe:

d) Who introduced you to religious beliefs and practices?
e) What were the rituals which were expected to be followed on a daily basis during childhood?
f) Stories told by grandparents (religious epics/stories of saints)?

8. Religious rituals marking rites of passage.

Probes:

f) Name-giving ceremony by *pandit/maulvi*, after how many days of birth?
g) Tonsure (*mundan/hakika*).
h) For Muslims, reading of Arabic and reciting Koranic verses.
i) Puberty rites after menarche (telling relatives, rituals, feast).
j) Marriage commenced through religious rites. What were those rites (*yajna, saptapadi, tali* for Hindus and *nikah nama* for Muslims)?

9. After marriage what were the visible changes about you?

Probes

e) Clothing.
f) Food.
g) Symbol of marriage.
h) Code of conduct.

10. At present what are the religious practices that you follow?

Probes

j) Prayers (frequency).
k) Visiting temple/mosque (which days of the week).
l) Listening to religious sermons/*pravachans* for Hindus and *istama* for Muslims (if yes, frequency).
m) Reading holy text.
n) Watching religious TV shows.
o) Radio message.
p) Fasting (reason for it).
q) Symbols of religion (thread around neck and wrist, *taviz*, veil or *burkha*).
r) Making wish *(mannat* for Muslims and *harke* for Hindus).

6. Why do you feel it is necessary to follow these rituals on a day-to-day basis?
7. What motivation/inspiration do you derive from your religion?
8. What is the role of religion in your life?
9. How do you interpret the philosophy of religion?

Probe:

c) Reading religious text.
d) Religious leaders.

10. What are the views of religious leaders on family issues?

Probes:

d) Children (how many).
e) Contraception.
f) Abortion.

11. Degree of commitment to the dictums of your religion.
12. Discussion of religious matters with husband, in-laws or friends and, if you do, which topics do you usually discuss?
14. In your opinion how should a good Hindu/Muslim woman behave towards husband, family members, in-laws, relatives etc.?
15. It usually happens that when people have some personal problem they resort to their religion through prayer or *mannat*. What is your experience in the same situation?

16. Expectations concerning children (son/daughter) conducting specific kind of rituals/prayers on a daily basis and its reason.
17. Do you play any role in the religious fairs that get organised in your village every year; what role do you play?

4. <u>Gender Dynamics</u>

11. What is your daily time schedule in and outside the house?
12. What according to you is a man's position in the family and community?
13. What according to you are the factors that contribute to a man's higher or lower status in the family and in the community?
14. What according to you are the factors that contribute to a woman's higher or lower status in the family and in the community?
15. How would you define your status in the family?

Probe

d) Respect that you receive from your wife, family, in-laws etc.
e) Decision making (health, education of children, etc.).
f) Ownership of assets in your name?

16. Has there been a change in your status over time?

Probe

a) Age.
b) Education.
c) Work status.
d) Marriage.
e) Fatherhood.

17. How vital is your opinion when some important decision is being made?
18. When you do something, which is not expected of you, how does your wife react to it?
19. What according to you is the ideal sex composition of a family?
20. Is it better to have more sons or daughters and why?
21. Who inherits the property (son or daughter in your family) and why is it justified?
22. If daughter/son is important then do you invest on the education and food of son and daughter equally? If not, why?

5. Group and Minority Identity

1. What is the proportion of Hindus/Muslims in your locality?
2. What is the nature of social relationships between the men of both communities?

Probe:

a) Do you men interact with them on a day-to-day basis?
b) Do you participate in each other's festival?
c) Do you visit each other?

3. Do you feel welcomed or part of the group when you are with people from the other community (Hindu/Muslim)?
4. What are the similarities between people of your community and people of other communities (Hindu/Muslim)?
5. What are the differences between people of your community and people of other communities (Hindu/Muslim)?
6. In general how do you perceive the relationship between the two communities (friendly, formal, workable, fights, bitterness)?
7. People from which community in your opinion are represented in government posts?
8. People from which community in your view have greater economic resources and opportunities?
9. Who do you think dominates the political and economic situation between the two communities?

6. Infant Mortality

1. Why do young children die in the first few days, weeks or months of their birth? What do people do to deal with it?

7. Sanitation and Hygiene

1. Is there safe and purified water at your home for drinking?
2. Did you use boiled water for a few days or months after the child's birth?
3. Did your house have proper waste disposal?
4. What sort of diapers did you use for the baby after birth?
5. How did you wash them and where?
6. After the child started drinking from a bowl or feeding bottle, did you sterilize that with boiling water properly?

Appendix D: Religious leader interview guideline

Religion, minority status and reproductive behaviour among Muslims and Hindus in India and Bangladesh.

Introduction

This study tries to explore the linkages of identity such as religion, minority status and gender on the decision making processes among Hindus and Muslims in India and Bangladesh. The guide is designed to help the interviewer in checking to ascertain whether the interview has covered all points necessary for the study.

1. Background

- Age.
- Can you read and write?
- Education (in years).
- Religion.
- If Hindu- caste and sub-caste.
- If Muslim- type (Sayeed, Sheikh, Moghul, Pathan).
- Language (Family, Others).
- Type of Family (Joint, Nuclear).
- Working status.
- Kind of occupation.

2. Village/urban area set up

1. What is the main economic activity in this area?
2. Which people of which religious community engage in which kind of economic activity?
3. What is the political situation in the area?
4. Who dominates the political situation (religion and caste) and in what way?

3. Marriage and Contraception

1. At what age do girls and boys get married in your community?
2. What according to you is the right age and why?
3. Is dowry taken in this area, if yes, in what form?
4. How many children should people have and why?
5. Knowledge of type of contraception and the ones commonly used.
6. Do people maintain spacing between children? If yes, how many years?
7. If sterilisation arises as an issue, probe why it is popular/unpopular.
8. Probe into the attitude of religious leaders in the use of sterilisation method.
9. What are your views regarding induced abortion?
10. Under what circumstances do people undergo induced abortion?
11. Where do people go to obtain an induced abortion?

4. Gender dynamics

1. What are his views on the role of women in society?
2. What role do women play in and out of the home in the village?
3. What are his views on Hindu and Muslim women (domestic and public sphere)?
4. What are his views on women's work participation?
5. What is the role of men in society?
6. What are his views on Hindu/Muslim men?

5. Religion

1. What are the tenets of the Hindu/Muslim religion?

2. Who made him aware of them?
3. What are the religious practices that he follows?
4. How committed is he in following them and why does he feel it necessary to follow them?
5. Does the Hindu/Muslim religion permit contraception (especially sterilisation) and abortion? If not, then give reason.

6. Group dynamics

1. What has been the history of the relationship between Hindus and Muslims (any fights, violence) in the area?
2. What does he think of the other religion (Hindu if he is Muslim and vice-versa) and the people of that religion?
3. What is his perception of the relationship between Hindus and Muslims?
4. During which occasions do they interact?
5. Do they celebrate festivals together? And in which way?
6. What are the similarities between Hindus and Muslims?
7. What are the differences between Hindus and Muslims?

7. Fading questions

1. What are the developmental programmes in action in the village/urban area?
2. What can be done further to bring greater development?

Appendix E: Health personnel interview guidelines

Religion, minority status and reproductive behaviour among Muslims and Hindus in India and Bangladesh.

Introduction

This study tries to explore the linkages of identity such as religion, minority status and gender on the decision-making processes among Hindus and Muslims in India and Bangladesh. The guide is designed to help the interviewer to ascertain whether the interview has covered all points necessary for the study.

1. Background

- Age.
- Can you read and write?
- Education (in years).
- Religion.
- If Hindu- caste and sub-caste.
- If Muslim- type (Sayeed, Sheikh, Moghul, Pathan).
- Language (Family, Others).
- Type of Family (Joint, Nuclear).
- Working status.
- Kind of occupation.

2. Village/urban area set up

5. What is the main economic activity in this area?
6. Which people of which religious community engage in which kind of economic activity?
7. What is the political situation in the area?
8. Who dominates the political situation (religion and caste) and in what way?

3. Hospital set-up

1. How many employees?
2. What functions do they carry out?
3. Nature of work in the hospital?

4. Role in pre-natal and post-natal care

Probes

a) What kind of immunisation is given and in which month?
b) How many check-ups during pregnancy and for what?
c) Advice on care during pregnancy.
d) Medication.
e) Child Immunisation and in which month?
f) Advice.

5. Interaction with people of different religion

1. What is the difference between Hindu women and Muslim women when they come to hospital?

Probe

a) What is the basic difference between Hindu/Muslim women in the hospital?
b) The way they approach the health workers?
c) How informed are they about their health status and that of their child?
d) Do they come alone or with their husband?
e) Their level of information on immunisation of mother and child?

6. Marriage and Contraception

12. At, what age do girls and boys get married?

13. What according to health worker her is the right age and why?
14. Is dowry taken normally and in what form?
15. How many children should people have and why?
16. Do they give information on contraception in the hospital?
17. Knowledge of type of contraception available.
18. Which method of contraception is common among Hindu and Muslim women?
19. Do people practise spacing between children? If yes, how far apart are Hindu and Muslim children?
20. What form of contraception is most popular and why?
21. Is there any incentive given to encourage the use of contraception?
22. What are your views regarding induced abortion?
23. Under what circumstance do people obtain an induced abortion?
24. Where do people go for an induced abortion?

7. Religion

6. What are the tenets of your religion?
7. Who made you aware of them?
8. What are the religious practices that you follow?
9. Does Hindu/Muslim religion permit contraception (especially sterilisation) and abortion, if not then give reason?

8. Minority status

8. What has been the history of the relationship between the Hindu and Muslim communities in the area?
9. What are the occasions in which people from both communities interact?
10. Do they celebrate festivals together? And in which way?
11. What are the similarities between Hindus and Muslims?
12. What are the differences between Hindus and Muslims?

9. Fading questions

1. What are the developmental programmes in action in the village?
2. What can be done further to bring greater development?

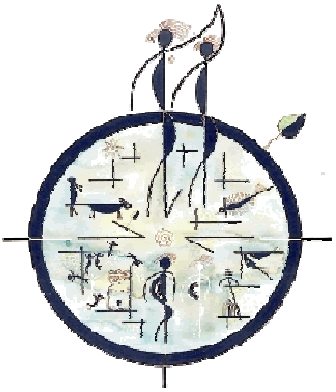
Appendix F: Complete coverage form

Households, Couple, Religion, Caste and Birth Enumeration						
Village name:			Street:		Name of Interviewer	
HH No	**Head of Household**	**HH Size**	**Names of Couple (15-44)**	**Religion**	**Caste**	**Birth in last 3 years**

Appendix G: Female survey questionnaire

Religion, minority status and reproductive behaviour among Muslims and Hindus in India and Bangladesh

Principal Investigator: Biswamitra Sahu



Population Research Centre
Faculty of Spatial Sciences
University of Groningen
The Netherlands

In Collaboration with

IER, Dharwad
ISEC, Bangalore
HDSU, icddr,b, Dhaka

Identification Particulars

Name of the village/block _____

Street Number _____

Household number _____

Name of Respondent _____

Name of Interviewer _____

Date of Interview _____

Interview Status: 1 Completed 2 Partially completed 3 Refused 4 Not available for interview 5 Other (Specify)

Section I: Household Particulars			
Sl.No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
H01	How many members are there in your family?	☐☐	
H02	Are your in-laws alive?	Both died.....1 Both surviving.....2 Father-in-law Surviving.....3 Mother-in-law Surviving.....4	→ H04
H03	Where do they live?	With us.....1 Somewhere else.....2	
H04	Do they live in the same village or somewhere else?	Same village.....1 Some other place..... 2	
H05	What is the main source of drinking water for members of your household?	PIPED WATER.....1 DUG WELL.....2 LAKE/POND/STREAM/ CANAL/.....3 Borewell..... .....4 OTHERS_____96	
Sl.No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**

H06	What is the main source of water used by your household for other purposes such as cleaning utensils, clothes, etc.?	PIPED WATER.....1 DUG WELL.....2 LAKE/POND/STREAM/ CANAL/.....3 OTHERS_____96	
H07	Where is the water source for drinking located?	IN OWN DWELLING.....1 IN OWN YARD/PLOT.....2 ELSEWHERE.....3	
H08	What kind of toilet facility do members of your household usually use?	FLUSH TOILET.....1 PIT LATRINE WITH SLAB.....2 NO FACILITY/USE OPEN SPACE OR FIELD.....3 OTHERS_____96	
H09	Does your household have: Electricity? A Mattress? A Pressure Cooker? A Chair? A Cot or Bed? A Table? An Electric Fan? A Radio? A B & W TV? A Colour Television? A Sewing Machine? A Mobile Phone? Land Telephone? A Computer? A Refrigerator? A Watch Or Clock? A Bicycle? A Motorcycle Or Scooter? A Animal-Drawn Cart? A Car? A Water Pump? A Thresher? A Tractor?	Yes No Electricity? 1 2 A Mattress? 1 2 A Pressure Cooker 1 2 A Chair? 1 2 A Cot Or Bed? 1 2 A Table? 1 2 An Electric Fan? 1 2 A Radio? 1 2 A B&W TV 1 2 A Colour TV 1 2 A Sewing Machine? 1 2 A Mobile Phone? 1 2 Land Telephone? 1 2 A Computer? 1 2 A Refrigerator? 1 2 A Watch Or Clock? 1 2 A Bicycle? 1 2 A Motorcycle Or 1 2 Scooter? A Car? 1 2 A Water Pump? 1 2 Animal-Drawn Cart 1 2 A Thresher? 1 2 A Tractor? 1 2	
Sl.No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**

H10	What type of fuel does your household mainly use for cooking?	WOOD.....01 KEROSENE.....02 Gas-Gobar .....03 GAS-LPG..... 04 OTHERS_____96	
H11	MAIN MATERIAL OF THE FLOOR. RECORD OBSERVATION.	**NATURAL FLOOR**.....**1** (MUD/CLAY/EARTH,SAND, DUNG) **RUDIMENTARY FLOOR**.....**2** (RAW WOOD PLANKS,PALM/BAMBOO) **FINISHED FLOOR**.....**3** (PARQUET OR POLISHED WOOD,VINYL OR ASPHALT, CERAMIC TILES,CEMENT,CARPET,POLISHED STONE/MARBLE/ GRANITE) **OTHER** _____ _____**96** (SPECIFY)	
H12	MAIN MATERIAL OF THE ROOF. RECORD OBSERVATION	**NATURAL ROOFING**.....**1** (NO ROOF,THATCH/PALM LEAF/REED/GRASS,MUD,SOD/MUD AND GRASS MIXTURE, PLASTIC/POLYTHENE SHEETING) **RUDIMENTARY ROOFING**.....**2** RUSTIC MAT,PALM/BAMBOO ,RAW WOOD PLANKS/TIMBER, UNFIRED BRICK,LOOSELY PACKED STONE) **FINISHED ROOFING**.....**3** (METAL/GI,WOOD,CALAMINE/CEMENT FIBER,ASBESTOS SHEETS,RCC/RBC/CEMENT/CONCRETE,ROOFING SHINGLES,TILES, SLATE, FIRED BRICK) **OTHER**_____**96** SPECIFY)	
H13	MAIN MATERIAL OF THE EXTERIOR WALLS. RECORD OBSERVATION	**NATURAL WALLS**.....**1** (NO WALLS,CANE/PALM/TRUNKS/BAMBOO,MUD,GRASS/REEDS/THATCH, **RUDIMENTARY WALLS**.....**2** (BAMBOO WITH MUD,STONE WITH MUD,PLYWOOD,CARDBOARD, UNFIRED BRICK, RAW WOOD/REUSED WOOD) **FINISHED WALLS**.....**3** **(**CEMENT/CONCRETE,STONE WITH LIME/CEMENT,FIRED BRICKS,CEMENT BLOCKS, WOOD PLANKS/ SHINGLES, GI/METAL/ASBESTOS SHEETS) **OTHER**_____**96** (SPECIFY)	

Sl.No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**

H14	TYPE OF WINDOWS. RECORD OBSERVATION	YES NO No Windows 1 2 WINDOWS WITH GLASS 1 2 Wooden Window 1 2	
H15	How many rooms are there in this household for sleeping?	ROOMS ☐☐	
H16	Does this household own this house or any other house?	Yes.....1 No.....2	
H17	Does this household own any agricultural land?	Yes.....1 No.....2 → H22	
H18	How much agricultural land does this household own? (IF NOT IN ACRES, SPECIFY SIZE AND UNIT)	ACRES ☐☐☐☐ ☐☐☐☐	
H19	Out of the total agricultural land how much land do you lease?	ACRES ☐☐☐☐ ☐☐☐☐	
H20	Out of the total agricultural land how much land is leased to others?	ACRES ☐☐☐☐ ☐☐☐☐	
H21	How much of the agricultural land is irrigated?	ACRES ☐☐☐☐ NONE.....9995	
Sl.No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**

H22	Does your household own any of the following animals?	YES NO COWS 1 2 BULLS 1 2 BUFFALOES 1 2 GOATS 1 2 SHEEP 1 2 FOWL 1 2	
H23	Does this household have a BPL (Yellow) card?	Yes.....1 No.....2 Don't Know.....98	

Section II Individual Particulars

Sl.No	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
V01	How old are you in completed years?	☐☐	
V02	How long have you been staying in this village/town/city?	Years..... ☐☐ Months..... ☐☐	
V03	Before marriage did you live in a village /town/city?	City.....1 Town.....2 Village.....3	
V04	What is your religion?	Hindu.....1 Muslim.....2	
V05	What is your sub-caste?	_____ ☐☐	
V06	What are the languages that you speak?	**Mark as many as mentioned** Bengali.....a Hindi.....b Urdu.....c Daccani.....d English.....e Others_____96	

Sl.No	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
V07	What language do you speak at home?	Bengali.....1 Hindi.....2 Urdu.....3 Daccani.....4 English.....5 Others_____96	
V08	Did you attend school in childhood/adulthood?	Yes.....1 No.....2	→ V09
V09	What is the highest standard completed in childhood/adulthood?	STANDARD..... ☐☐ Years..... ☐☐	
V10	Can you read and write?	Yes.....1 No.....2	→ V13
V11	Check V09 Standard 5 and below Check V10: yes ↓	Check V09 Standard 6 & above and V10:yes ↓	
V12	How often do you read a newspaper or magazine?	ALMOST EVERYDAY.....1 AT LEAST ONCE A WEEK....2 LESS THAN ONCE A WEEK.....3 NOT AT ALL.....4	
V13	**Check H08** How often do you listen to the radio?	ALMOST EVERYDAY.....1 AT LEAST ONCE A WEEK....2 LESS THAN ONCE A WEEK.....3 NOT AT ALL.....4	
V14	**Check H08** How often do you watch television?	ALMOST EVERYDAY.....1 AT LEAST ONCE A WEEK....2 LESS THAN ONCE A WEEK.....3 NOT AT ALL.....4	
V15	Do you usually go to a cinema hall or theatre to see a movie at least once a month?	Yes.....1 No.....2	

Sl.No	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
V16	Are you a member of any self-help group (Stree Shakti Sangh) with which you save money?	Yes.....1 No.....2	

Section III: PUBERTY & MARRIAGE

V17	At which age did you first menstruate?	MONTH..... ☐☐ DON'T KNOW MONTH.....98 YEAR..... ☐☐☐☐ DON'T KNOW YEAR……9998	
Note	Now I will ask you for some information about your husband		
V18	What is the age of your current husband in completed years?	☐☐	
V19	Did your husband attend school/college?	Yes.....1 No.....2	→ V21
V20	What was the highest standard he completed?	STANDARD..... ☐☐	
V21	What kind of work does he do?		
V22	Does your husband stay in the same house, or due to work or some other reason is he staying elsewhere?	LIVING WITH HUSBAND.....1 STAYING ELSEWHERE.....2	→ V23

Sl.No	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
NOTE	Please do not take it otherwise since I need to ask some personal information regarding your marriage. It sometimes happens that people marry more than once. Thus I will ask about your marriage.		
V23	Besides yourself, does your husband have another wife or woman?	Yes.....1 No.....2 Don't Know.....98	
V24	Have you been married once or more than once?	ONLY ONCE.....1 → V25 MORE THAN ONCE.....2 → V25,V26	
V25	What was your age at the time of first marriage?	Age..... ☐☐ Which year ☐☐☐☐	
V26	What was your age at the time of second marriage?	Age..... ☐☐ Which year ☐☐☐☐	
V27	Now tell me some of your views on marriage. What are the attributes of a prospective groom?	**Cross as many mentioned** Good Health.....a Education.....b Family background.....c Property.....d No bad habits.....e Responsible.....f Sincerity..... g Working..... h Others specify_____96	

Sl.No	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
V28	What are the attributes of a prospective bride?	**Cross as many mentioned** Beauty.....a Skills.....b Reading Quran.....c Family asset.....d Education.....e Adjustable.....f Good at domestic chores.....g Character.....h Restricted conduct.....i Obedient.....j Dowry.....k Others specify_____96	
V29	Did you marry someone of the same religion?	Yes.....1 No.....2	→ v33
V30	Did you marry someone who belongs to your caste/sub-caste?	Yes.....1 No.....2	
V31	Was your husband a relative of yours?	Yes.....1 No.....2	→ V33
V32	What is the relationship?	Maternal Uncle.....1 Maternal Uncle's son....2 Paternal Aunt's son 3 Others Specify.....96	
V33	Was there any demand for dowry?	Yes.....1 No.....2	→ C01
V34	What was it?	Cash.....a Electronic goods.....b Jewellery.....c Furniture.....d Utensils.....e Transport in marriage..f Clothes g Clock/watch h Other.....96	

Section IV: Contraception

C01	**How many children do you have?**	☐☐	
C02	Have you ever been pregnant?	Yes.....1 No.....2	→ C04
C03	What was your age in completed years when you got pregnant for the first time?	☐☐	
C04	Have you ever used any contraception?	Yes.....1 NO.....2	→ C06
C05	Which method?	Copper-T.....1 Injectibles.....2 Condom.....3 Abstinence.....4 Withdrawal.....5 Pills.....6 Rhythm.....7 Vasectomy.....8 Tubectomy.....9	→ C12
C06	Are you currently using any contraception?	Yes.....1 NO.....2	→ C08

Sl.No	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
C07	Which method?	Copper-T.....1 Injectibles.....2 Condom.....3 Abstinence.....4 Withdrawal.....5 Pills.....6 Rhythm.....7	→
C08	Do you want more children?	YES.....1 NO.....2	→ C10
C09	How many more children do you want?	☐☐	→ C12
C10	Are you sterilised?	YES.....1 NO.....2	→ C12
C11	What is the reason for not getting sterilised?	Health.....1 Religion.....2	

		Others (Specify)_____ 96	
C12	How much influence does your husband have on your decision to use contraception?	Completely.....1 Partially.....2 None.....3 Not Applicable.....99 →	C15
C13	How much of influence do your friends/sibling etc. have on your decision to use contraception?	Completely.....1 Partially.....2 None.....3 Not Applicable.....99 →	C15
C14	Can you make a decision about the use of contraception on your own?	YES.....1 NO.....2	
Sl.No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
C15	Do you discuss with anyone about which contraception to use?	YES.....1 NO.....2 →	C17
C16	With whom do you discuss matters regarding contraception?	Husband.....a In-law.....b Parents.....c Friends.....d Neighbour.....e Relatives .....f Others (Specify)_____96	
C17	Does your husband show interest in matters of contraception?	YES.....1 NO.....2 Not Applicable 99	
C18	In your family who decides how many children you should have?	**Multiple** Self.....a Husband.....b In-laws.....c All together.....d Others_____96 (Specify)	
	Note: Now I would like to ask you about pregnancy and other matters.		

C19	**Check C07 proceed if not sterilised.** Are you pregnant now?	YES.....1 NO.....2 UNSURE.....3	→ C21
C20	How many months are you pregnant (in completed months)?	☐	
C21	What do you think determines how many children people should have?		

Section V Fertility History			
F01	**Now I would like to ask about all the births you have had so far.** Have you ever given birth?	YES.....1 NO.....2 →	F17
Sl.No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
F02	How many children do you have including those living elsewhere and those who got married?	Sons ☐ Daughters ☐	
F03	About the children that you have given birth to, how many of them were born alive but later died?	Sons ☐ Daughters ☐	
F04	CHECK F02 and F03: Just to make sure that I have this right: you have had in TOTAL _____ births so far. Is that correct? Yes ☐ ↓ NO ☐ → PROBE AND CORRECT AS NECESSARY.		
F05	CHECK F02 and F03: ONE OR MORE BIRTHS ☐ ↓ NO ☐ BIRTHS →		F17

F06	F07	F08	F09	F10	F11	F12 →	F13 →	F14 →
What name was given to your (first/next) baby?	Is (NAME) a boy or a girl?	In what month and year was (NAME) born? PROBE: What is his/her birthday in completed years?	(NAME) still alive?	IF DEAD: How old was (NAME) when he/she died? IF '1 YR', PROBE: How many months old was (NAME)? RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.	Were there any other live births between (NAME OF PREVIOUS BIRTH) and (NAME), including any children who died after birth?	Check F08 if year 2002 then proceed After the birth of (NAME) how long did it take for your menstruation to return?	Check F08 if year 2002 then proceed For what duration did you breastfeed (Name)?	Check F08 if year 2002 then proceed For how long did you abstain from sex with your husband?
1	Boy -1 Girl -2	Month Year	Yes -1 No - 2 ↓ F10	DD MM YY	Yes -1 No - 2	DD MM YY	DD MM YY	DD MM YY
2	Boy -1 Girl -2	Month Year	Yes -1 No - 2 ↓ F10	DD MM YY	Yes -1 No - 2	DD MM YY	DD MM YY	DD MM YY
3	Boy -1 Girl -2	Month Year	Yes -1 No - 2 ↓ F10	DD MM YY	Yes -1 No - 2	DD MM YY	DD MM YY	DD MM YY
4	Boy -1 Girl -2	Month Year	Yes -1 No - 2 ↓ F10	DD MM YY	Yes -1 No - 2	DD MM YY	DD MM YY	DD MM YY
5	Boy -1 Girl -2	Month Year	Yes -1 No - 2 ↓ F10	DD MM YY	Yes -1 No - 2	DD MM YY	DD MM YY	DD MM YY
6	Boy -1 Girl -2	Month Year	Yes -1 No - 2 ↓ F10	DD MM YY	Yes -1 No - 2	DD MM YY	DD MM YY	DD MM YY
7	Boy -1 Girl -2	Month Year	Yes -1 No - 2 ↓ F10	DD MM YY	Yes -1 No - 2	DD MM YY	DD MM YY	DD MM YY

Sl.No	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
F15	Check F08 if year 2002 then proceed What did you feed your baby immediately after birth?	Sugar water.....1 Honey.....2 Ghutti.....3 Breast Milk.....4 Others_____96 (Specify)	→ F17
F16	Check F08 if year 2002 then proceed After how much time after birth did you feed your child with your milk?	Minutes ☐☐ Hours ☐☐ Days ☐☐	
	Note: Please do not feel bad about some details which I am going to ask about your fertility history. Because all pregnancies do not result in live births.		
F17	Have you ever had a pregnancy that resulted in Stillbirth YES.....1 NO.....2 Spontaneous Abortion YES.....1 NO.....2 Induced Abortion YES.....1 NO.....2 NOTE THE NUMBER	☐ ☐ ☐	

Section VI Gender dynamics			
G01	Other than your housework, have you worked for cash/kind in the last 12 months?	Yes.....1 No.....2 →	G06
Sl.No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
G02	What kind of work do you do?		
G03	DO you usually work at home or away from home?	Home.....1 Away.....2	

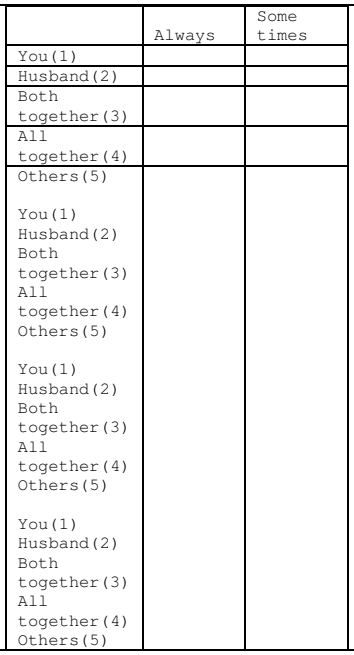
G04	How many months in a year do you work?	Months ☐☐	
G05	Can you spend the money you earn as you wish?	Yes.....1 No.....2 → G07	
G06	Are you given some money which you can spend as you wish?	Yes.....1 No.....2 Not given any money.....3	
G07	In a day how many hours do you spend doing housework?	In Hours ☐☐ Don't Know.....98	
G08	How often in a day/week/month do you go out (e.g. to shop, work for money)?	Everyday.....1 Once a week.....2 Few times in a week.....3 Once a month.....4 Few times in a month.....5 Not at all.....6 Don't Know.....98	
G09	Does your husband help you with the household chores	Yes.....1 No.....2	

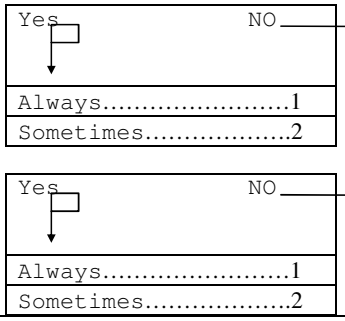
Sl. No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
G10	In your opinion, in what way does a woman's position improve in the family?	Maintaining household a Taking domestic responsibility.....b Well informed(Educated).....c By maintaining good relation with everyone d Earning money..... e Obedient.....f Patient..... g Others..... h	
G11	Given your current situation in the family, are you satisfied with your position in the family?	Yes.....1 → G13 No.....2	

G12	What can you do to improve your position in the family?		
G13	In what way does a man's position improve in the family?	**Multiple response** Providing for household.....a Well informed..... b No bad habits..... c Working.....d Sociable..... e Others..... f	
Sl. No	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
G14	Has there been a change in your status in the family with events mentioned below? 1. Has marriage improved or lowered your status? 2. **Check F07 whether she is mother of daughter** Has bearing a female child improved or lowered your status? **3. Check F07 whether she is mother of son.** Has bearing a male child improved or lowered your status?		
G15	**For Muslim** Do you wear a "burkha"/Veil" when you go out?	Yes.....1 No.....2 Not Applicable 99	
G16	Do you approve of women wearing a "burkha" in public?	Yes.....1 No.....2 Not Applicable 99	

	*H	*L	*S
Marriage			
Bearing female child			
Bearing male child			

H–higher, L– lower
S–Same

Sl.No	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
G17	Who makes decisions on the following? 1. Decision about health care for yourself? 2. Decision about making major household purchase? 3. Decision about purchase for daily household needs? 4. Decision about visiting your friends and relatives?		
G18	Can you go to the following places alone? a)To the city for marketing/shopping?	Yes NO → Always.....1 Sometimes.....2	G18b
	b)To buy grocery	Yes NO → Always.....1 Sometimes.....2	G18C
	c) To the city hospital/nursing home	Yes NO → Always.....1 Sometimes.....2	G18d
	d)To primary health centre	Yes NO → Always.....1 Sometimes.....2	G18e

	e)To the cinema, play, theatre f)To maternal home		G18f G19
G19	**If No to any answer in G19** Why can you not go alone?	Not safe alone 1 Restriction on going alone 2 Women with good upbringing don't go out alone 3 Does not know the route 4 Does not like going alone 5 Others _____96 (Specify)	
G20	Can you argue with your husband on issues of marriage and education of child if you disagree with him?	Yes.....1 No.....2	
G21	Can you argue with your husband about some of his habits which you dislike?	Yes.....1 No.....2	
G22	If you do something which is not expected of you(e.g.,if you don't listen to what he says, do something without permission), how does your husband react to it?	**Multiple Response** Discusses..... a Doesn't say any thing b Asks for explanation c Asks not to do it again....d Gets annoyed and scolds.. e Beats.....f Others_____96	
G23	Do you have a bank/stree shakti account which you use independently?	Yes.....1 No.....2	
G24	How many sons and daughters should a woman have?	1 Son 1 Daughter.....1 2 Sons 1 Daughter.....2	

		1 Son 2 Daughters.....3 2 Sons 2 Daughters.....4 Either son or Daughter is fine 5 Others.....96	
G25	Give reason for the previous answer		
G26	When spending on education should one spend more on one's son/daughter ?	Son.....1 Daughter.....2 Both equally.....3	

Section VII: Religiosity

	Questions	Response	Code
	CHECK V05 for religion		
R01	Do you worship/*puja*/*fateha* God at home?	Yes.....1 No.....2 → R03	
R02	How often do you worship/*puja*/*fateha* God at home?	Once a day .....1 Twice in a day.....2 Once a week 3 Few times per week.....4 Few times per month.....5 Few times per year.....9 Others_____96	
R03	Do you pray/*namaz* to God at home?	Yes.....1 No.....2 → R05	
R04	How often do you pray/*namaz* to God at home?	Once a day .....1 Twice in a day.....2 Once a week.....3 Few times per week.....4 Few times per month.....5 Few times per year.....9 Others_____96	
	Questions	**Response**	**Code**
R05	Do you go to listen *pravachan*/*istama*/sermons?	Yes.....1 No.....2 → R07	
R06	How often do you attend religious *pravachan*/*istama*/sermons?	Once a week..... ...1 Once in a year ...2 Few times per week.....3 Few times per month.....4 Few times per year.....5 Others_____96	
R07	**Check V10**	Yes.....1	

	Do you chant mantra/*chalisa*/*suree*/ Kalma? Hindu example: *Gayatri mantra*, *Hanuman chalisa* Muslim example: *suree*,*kalma*	No.....2	→ R09
R08	How often do you chant?	Once a day .....1 Twice in a day.....2 Once a week 3 Few times per week.....4 Few times per month.....5 Few times per year.....9 Others_____96	
R09	Do you follow any religious programmes on TV or radio?	Yes.....1 No.....2 Not Applicable 99	→ R11
R10	How often do you watch or listen to religious programmes on TV or radio?	Once a day .....1 Few times per week.....2 Few times per month.....3 Few times per year.....4 Not at all.....5	
R11	**Check V08 for school** Was the school you attended aided or maintained by the government or missionaries?	Govt-aided .....1 Missionary.....2 Not Applicable 99	→ R14
	Questions	**Response**	**Code**
R12	Which religion did the missionaries belong ?	Islam.....1 Christianity.....2 Hindu.....3 Others (Specify)_____	
R13	Apart from education,did you receive religious instruction?	Yes.....1 No.....2	
R14	Apart from school did you learn Urdu/Sanskrit in your childhood?	Yes.....1 No.....2	
	Religious Activity Scale		
R15	Do you fast for religious reasons?	Yes.....1 No.....2	→ R20
R16	How often do you fast for	Few times per week.....1	

	religious reasons?	Few times per month.....2 Once/Twice per month 3 Once a year.....4 Few times per year.....5 Not at all.....6 Others.....7	
R17	On what occasions do you fast?	Moharram.....a Hunnime.....b Roja.....c Sankasti.....d Ekadasi e Others_____f	
R18	Which day of the week is an auspicious day in your opinion?	Monday.....a Tuesday.....b Wednesday.....c Thursday.....d Friday.....e Saturday.....f Sunday.....g None.....h	
R19	Do you fast on that/those day/s?	Yes.....1 No.....2	
	Questions	**Response**	**Code**
R20	Do you take part in any (small prayer group/ religious study group) *jammat/mandali*?	Yes.....1 No.....2 →	R22
R21	How frequently do you take part in small prayer groups or religious study groups?	Once a day .....1 Few times per week.....2 Few times per month.....3 Few times per year.....4 Others_____ 96	
R22	Do you visit a temple or *dargah*?	Yes.....1 No.....2 →	R24
R23	How frequently do you visit a temple or *dargah*?	Once a day .....1 Once a week.....2 Few times per week.....3 Few times per month..... 4 Few times per year.....5 Others_____ 96	
R24	Are you vegetarian or non-vegetarian?	Vegetarian.....1 Non-vegetarian.....2 →	R26

R25	Are you vegetarian for religious or other reasons?	Religious.....1 Others.....2	
R26	**Check Religion/Age of child** Did you perform religious rites/*rasam*/*sanskar* for your child's:	**Multiple Response**	
	Name giving	Yes No NA	
	Mundan/*Hakika*	Yes No NA	
	Ear-piercing ceremony	Yes No NA	
	Puberty	Yes No NA	
	Marriage	Yes No NA	
	Sunti(circumcision)	Yes No NA	
	Thread ceremony	Yes No NA	

	Questions	**Response**	**Code**
R27	Which God/s do you believe in?	**Multiple Response** Allah.....a Sadhu baba.....b Pir baba.....c Shiva.....d Mehboobsumani.....e Vishnu.....f Yellama.....g Basaveshwar.....h Mallikarjun.....i Others_____96	
	RELIGIOUS CONFIRMATIVITY		
R28	Is it important for you to follow religious practices mentioned above?	Yes.....1 No..... 2 →R30	
R29	How important is it for you to follow religious practices mentioned above?	High.....1 Average.....2 Low.....3 Not at all.....4 Don't know.....98	

R30	Why do you think it is necessary to follow the religious practices mentioned earlier?	**Multiple response** Fear of God.....a Accountability when we go back to heaven.....b Peace of mind.....c Right path of conduct.....d Feels good.....e Have been doing so since childhood f Good for the family g Others.....h	
	Questions	**Response**	**Code**
R31	Are you committed to following these religious practices on a daily basis?	Yes.....1 No.....2 →	R33
R32	How committed are you in following these religious practices on a daily basis?	High.....1 Average.....2 Low.....3 Don't know.....98	
R33	Where does your knowledge of religion come from?	Religious Texts... ...1 leaders.....2 both ....3 Elders of family 4 Others	
R34	When you face any problem in life do you do any *harke/mannat* to get over it?	Yes.....1 No.....2	
	SUBJECTIVE RELIGIOSITY		
R35	Do you think you are religious?	Yes.....1 No.....2 →	R37
R36	How religious would you say you are?	High.....1 Average.....2 Low.....3 Not at all.....4 Don't know.....98	
R37	When you were young was religion important at home?	Yes.....1 No.....2 →	R39

R38	How important was religion in your home when you were young?	High.....1 Average.....2 Low.....3 Not at all.....4 Don't know.....98	
	Questions	**Response**	**Code**
R39	Do you think it is necessary for you to make your children aware of your religious beliefs and practices?	Yes.....1 No.....2 →	R41
R40	How necessary is it for you to make your children aware of your religious beliefs and practices?	High.....1 Average.....2 Low.....3 Not at all.....4 Don't know.....98	
R41	What role does religion play in your life?		

Section VIII: Minority Status

MS1	To which religious community do people who live in this locality belong?	**Circle as many as reported** Hindus.....a Muslims.....b Christians.....c	
MS2	**For Muslims** Of the religious community you mentioned, which one has the most followers?	Hindus.....1 Muslims.....2 Christians.....3	
MS3	**For Hindus** Of the religious community mentioned you mentioned, which has the second highest number of followers?	Hindus.....1 Muslims.....2 Christians.....3	

	Questions	Response	Code
	Cultural Difference/Similarity		
MS4	**For Hindus** If you compare your community with the biggest community (majority)what are the similarities and differences in the following areas?	**For Muslims** If you compare your community with the second largest community (minority)what are the similarities and differences in the following areas?	
MS4.1	Clothes	Same.....1 Different.....2	
MS4.2	What is the rate of women's work participation?	Same.....1 Higher.....2 Lower.....3	
MS4.3	Restriction on food	Same.....1 Different.....2	
MS4.4	What is their level of political participation?	Same.....1 Higher.....2 Lower.....3	
MS4.5	What is the level of dowry/bride price?	Same.....1 Higher.....2 Lower.....3	
MS5	In which sector do they work?	Agriculture.....1 Business.....2 Salaried.....3	

	Questions	Response	Code
MS6	Do you participate in each other's festivals?	Yes.....1 No.....2	
MS7	Do you feel welcome when you meet and interact with people from the other community?	Yes.....1 No.....2	
MS8	What is the nature of relationship between both communities?	Friendly.....1 Cordial.....2 Bitter.....3 Violent.....4	

	Section IX: Anthropometric measurements		
Am1	Height	Ft Inch	
Am2	Weight	Kgs	

	Section X: Observations		
OM	Observe woman	*Sindur* a Toe ring b Thread on hand c Thread on neck d *Kumkum* e *Bibhuti* f	
OC	Observe child	Thread on Hand a Thread on neck b	
OH	Observe house	Picture of God a Framed inscription b Statue of God c	
	Do you want your child to be educated?	Yes.....1 No.....2 N A 9	

Samenvatting

Religie, minderheidspositie en reproductief gedrag onder Moslims en Hindus in India en Bangladesh

Inleiding

Religie speelt een belangrijke rol in het bepalen van reproductief gedrag. We zouden daarom een bepaalde regelmatigheid kunnen verwachten in het vruchtbaarheidsniveau van mensen die tot eenzelfde religie behoren. Ze zouden immers worden geleid door dezelfde religieuze principes die gedrag en attitudes ten aanzien van vruchtbaarheid en het gebruik van voorbehoedsmiddelen zouden bepalen. Er bestaan verschillende verklaringen voor de invloed van religie op het reproductief gedrag van mensen. Deze worden hypotheses genoemd die worden ondergebracht in de volgende 4 categorieën:

- de '**characteristic hypothesis'** die beweert dat de verschillen in vruchtbaarheid tussen religieuze groepen slechts het resultaat zijn van verschillen in demografische en sociaal-economische kenmerken van deze groepen.
- de '**particular theology hypothesis'** die beweert dat religieuze doctrines en ideologieën het gebruik van voorbehoedsmiddelen en reproductief gedrag beïnvloeden.
- de '**minority status hypothesis'** die beweert dat marginalisering, gevoelens van onveiligheid, en een gebrek aan sociale mobiliteit van (religieuze) minderheden invloed hebben op het gebruik van voorbehoedsmiddelen en vruchtbaarheid.
- de "i**nteraction hypothesis'** die beweert dat verschillen in vruchtbaarheid afhankelijk zijn van de interactie tussen de sociaal economische achtergrond van religieuze groepen en de lokale oriëntatie van deze groepen ten opzichte van voortplanting en gebruik van voorbehoedsmiddelen.

In de afgelopen jaren wordt steeds meer aandacht besteed aan vruchtbaarheid van Moslims, zowel op academisch als politiek niveau. De maatschappelijke aandacht voor vruchtbaarheid van Moslims komt voort uit een interpretatie van islamitische principes als zijnde tegen het gebruik van voorbehoedsmiddelen zoals sterilisatie en tegen abortus. De indruk dat moslims pro-natalistisch zouden zijn wordt bestreden door onderzoekers die aangeven dat het onmogelijk is om een eenduidig vruchtbaarheidspatroon van moslims te onderscheiden over de gehele wereld.

In de Zuid Aziatische context hebben Indiase Moslims een hoger vruchtbaarheidscijfer in vergelijking met Indiase Hindus. De zogenoemde Completed Family Size (CFS) in India is onder Moslims 5.3 kinderen en bij Hindus 3.9 kinderen (NFHS 3, 2007). In Bangladesh is de CFS onder Moslims 4.7 kinderen, onder Hindus 4.2 kinderen (BDHS 2007). In India is het onderwerp van de vruchtbaarheid van Moslims sterk gepolitiseerd: van Moslims wordt soms gezegd dat ze de Hindu meerderheid willen benaderen in aantal, en overstijgen. Moslims in India zijn de grootste religieuze minderheid, 13.4 procent van de totale bevolking. In Bangladesh zijn ze de religieuze meerderheid (87.8 procent). Ter vergelijking: Hindus zijn een religieuze meerderheid in India (80.5 procent) en de grootste religieuze minderheid in Bangladesh (9.3 procent). Deze unieke Hindu-Moslim samenstelling van beide landen biedt een uitstekende 'setting' om onderzoek te doen naar zowel de rol van religie als minderheidsstatus in het vruchtbaarheidspatroon van de twee religieuze groepen.

Onderzoeksdoel en onderzoeksvragen

Dit onderzoek heeft de volgende doelen:

1. Inzicht krijgen in de rol van religie en minderheidsstatus op vruchtbaarheidsgedrag in het vergelijkend perspectief van India en Bangladesh.

Hierbij horen de volgende specifieke onderzoeksvragen:

1.1 Wat is het effect van religieuze minderheidsstatus op vruchtbaarheid, in een vergelijking tussen India en Bangladesh, en binnen India zelf?

1.2 Wat is het effect van religie in het verklaren van verschillen in vruchtbaarheid tussen Hindus en Moslims in India en Bangladesh?

1.3 Wat kunnen we leren van een vergelijking van het reproductief gedrag van Moslims in zowel India als Bangladesh?

2. Inzicht krijgen in de rol van 'agency' binnen het religieuze domein van reproductief gedrag, in een vergelijking tussen India en Bangladesh.

Hierbij behoort de specifieke onderzoeksvraag:

2.1 Zijn vrouwen in staat om hun Moslim religie te 'onderhandelen' in het realiseren van hun reproductieve aspiraties, in een vergelijkend perspectief van India en Bangladesh?

Theoretisch raamwerk

Demografisch onderzoek in waarin vruchtbaarheid en religie in Zuid Azië aan elkaar worden gecorreleerd, behandelen religie vaak als een culturele 'zwarte doos'. D.w.z. deze studies gaan niet in op de onderliggende processen via welke religie een invloed heeft op reproductief gedrag. Het huidige onderzoek probeert dit onderliggende proces *wel* te begrijpen en te verklaren.

De 'structuration theory' (Giddens 1984) geeft richting aan het onderzoek ten einde de macro-micro relaties te duiden en het reproductieve gedrag van de twee groepen te verklaren. Met het macro niveau bedoelen we hier de samenleving, sociale systemen en instituties. Met het micro niveau, of 'agency', doelen we op individuele acties, interacties, interpretaties en betekenisgeving. De 'structuration theory' beargumenteert dat er een onderling-afhankelijk dualisme bestaat tussen 'agency' en structuur ('duality of structure').

Het onderzoek past daarnaast ook het theoretisch raamwerk van Bongaarts en Potter (1983) toe betreffende de directe determinanten van vruchtbaarheid zoals het gebruik van voorbehoedsmiddelen, abortus, en huwelijkssluiting.

Data en methode

Om de eerste onderzoeksvraag (1.1) te beantwoorden werden secondaire data geanalyseerd waaronder de Demographic Health Survey (DHS) in India (National Family Health Survey -NFHS genoemd) en Bangladesh; en de volkstelling in India. Om de andere onderzoeksvragen te beantwoorden werden primaire data verzameld. Bij deze dataverzameling werd een 'mixed-method' onderzoeksdesign toegepast, d.w.z. een samengaan van kwalitatieve (diepte-interviews en sleutelinformanten interviews onder 112 participanten) en kwantitatieve (enquête, onder 800 respondenten) onderzoeksmethoden. De kwantitatieve en kwalitatieve methoden zijn stapsgewijs toegepast waarbij de methoden elkaar complementeerden en bijdroegen aan elkaars ontwikkeling.

Belangrijkste resultaten

1. Analyse van Indiase data op districtsniveau (data uit de volkstelling) laat het volgende zien: hoe kleiner het aandeel van een religieuze minderheidsgroep (hetzij Moslim hetzij Hindu) in de totale districtsbevolking, hoe hoger de totale vruchtbaarheid (TFR). Dit resultaat lijkt de 'minority hypothesis' te bevestigen. De analyse laat ook zien dat de negatieve correlatie tussen minderheidsgroepering en vruchtbaarheid zich niet beperkt tot één religie, d.w.z. Moslims (0.05 level), maar dat de bevinding ook geldt -en zelfs sterker- voor de Hindus (0.01 level).
2. De hogere vruchtbaarheid onder Moslim minderheden op districtsniveau interpreteren we als het zijnde het resultaat van de sociaal economische achterstand van Moslims. De plekken waar Moslim minderheden wonen (vaak geïsoleerde wijken), zijn veelal plekken met inadequate sociaal economische infrastructuurvoorzieningen. D.w.z. er is een gebrek aan gezondheidsvoorzieningen, scholen en communicatievoorzieningen in de Moslim leefgemeenschappen. Hierdoor is het gebruik van de voorzieningen lager onder

Moslims, en kan er minder sprake zijn van 'informed choice' ten aanzien van gezondheid, family planning, of scholing.

3. De districten waar Hindus de minderheid vormen, of te wel waar Moslims in de meerderheid zijn, zijn dus traditioneel verwaarloosd wat betreft infrastructurele voorzieningen, zoals aangegeven door de overheid van India (Government of India 2006). Derhalve redeneren we dat Hindus die in Moslim-meerderheid districten wonen dezelfde inadequate voorzieningenstructuur ervaren als Moslims in het gebied. Dit zou de relatief hogere vruchtbaarheid van ook Hindu minderheden kunnen verklaren.
4. Religie is op twee manieren gemeten in het onderzoek. Ten eerste als 'behorend tot een bepaalde religie' en ten tweede als 'mate van religieus zijn'. Dit laatste is gemeten via de zogenaamde 'religiosity index', samengesteld -voor beide religies- uit lokale religieuze indicatoren.

   Moslims moeders blijken hun tweede en derde kind eerder te krijgen dan Hindu moeders; d.w.z. ze hebben korte intervallen tussen de geboortes van twee kinderen. Een analyse van de invloed van 'religiosity' op de duur van deze intervallen laat geen effect zien. Meer religieuze moeders krijgen niet sneller hun tweede en derde kinderen. Verder blijkt dat Moslim vrouwen in India een hogere vruchtbaarheid hebben dan Moslim vrouwen in Bangladesh. We kunnen concluderen dat religieus Islamitische principes niet het vruchtbaarheidsgedrag van Moslim vrouwen verklaren. Derhalve wordt de 'particularistic hyphothesis' hier verworpen.
5. Een mogelijke verklaring voor het verschil in Moslim vruchtbaarheid tussen vrouwen in India en Bangladesh zou kunnen zijn dat er een verschil is in het gebruik van voorbehoedsmiddelen in beide landen. In beide landen lijken Moslim vrouwen een voorkeur te hebben voor het gebruik van tijdelijke methoden (zoals pil, prikpil, condoom), in plaats van zogenoemde 'finale' methoden (zoals sterilisatie). Echter, Moslim vrouwen in India laten zich wel relatief vaker steriliseren -terwijl ze ook tijdelijke methodes gebruiken- dan Moslim vrouwen in Bangladesh die vooral tijdelijke voorbehoedsmiddelen gebruiken. Indiase moslims vrouwen kiezen daarentegen wel weer veel minder voor sterilisatie dan

Indiase Hindu vrouwen dat doen. Dit is gerelateerd aan het ontraden van sterilisatie binnen de Islam.

In dit onderzoek beargumenteren we dat de sleutel tot het begrijpen van het hogere vruchtbaarheidscijfer van Moslims in India ligt bij de 'family planning' methode sterilisatie.

6. De hogere vruchtbaarheid onder Moslims in India kan namelijk worden verklaard vanuit de barrières die Moslim vrouwen in India tegen komen (in tegenstelling tot vrouwen in Bangladesh) binnen het bestaande 'family planning' programma. Moslim vrouwen en mannen worden beperkt in hun keuzes voor voorbehoedsmiddelen binnen het Indiase 'family planning' programma dat al decennia lang gericht is op sterilisatie van vrouwen. Moslim vrouwen en mannen in Bangladesh daarentegen hebben vrij toegang tot het Bangladeshi 'family planning' programma dat vooral tijdelijke methoden aanbiedt die door de Islam worden toegestaan.

   Aan Moslim stellen in India die methoden gebruiken die ontraden worden (sterilisatie en abortus) worden sancties opgelegd. Moslims in Bangladesh ervaren deze sancties niet omdat ze tijdelijke methoden kunnen gebruiken. Verder gelden er voor jonge vrouwen en mannen in India ongelijke sekse en machtsverhoudingen. Zoals eerder aangegeven, Moslims in India wonen op meer geïsoleerd plekken in de samenleving; een gevolg van de historische verhoudingen en politieke spanningen tussen Moslims en Hindus. In de staat Karnataka in India speelt daarbij ook nog een verschil in taal: Moslims spreken Dhakani, een taal die afwijkt van de 'reguliere' taal van de staat, Kannada. Dit verschil in taal draagt nog verder bij aan de relatieve isolatie van de Moslim minderheid. Moslims in Bangladesh kennen al deze nadelen niet: diffusie van informatie over bijvoorbeeld voorbehoedsmiddelen wordt daar niet tegengehouden door segregatie van woongebieden.

7. Het onderzoek laat verder zien dat Moslim vrouwen, wat betreft hun eigen reproductie, geen passieve volgers zijn van de Islamitische regels. Ze nemen een actieve rol in in het bepalen van de grootte van hun familie. De verschillen in

context tussen India en Bangladesh leiden tot verschillen in strategie die vrouwen volgen op het gebied van hun reproductie.

8. Indiase Moslim vrouwen hebben minder mogelijkheden wat betreft het gebruik van voorbehoedsmiddelen vanwege de sterke nadruk op het gebruik van sterilisatie in het Indiase 'family planning' programma. Ook – zo vindt ons onderzoek- ervaren Indiase Moslim vrouwen relatief meer druk van hun familie om zich te onthouden van sterilisatie en abortus. Echter, de vrouwen zijn wel in staat om te onderhandelen, ten aanzien van religie en hun aspiraties voor hun kindertal: ze zwijgen en gebruiken voorbehoedsmiddelen zonder dat familieleden het weten.
9. Daarentegen hanteren Bangladeshi Moslim vrouwen juist religieuze redeneringen voor het gebruik van voorbehoedsmiddelen of het ondergaan van een abortus. Ze redeneren bijvoorbeeld dat ze met hun gedrag een relatief kleinere zonde begaan. Bijvoorbeeld, het gebruik van tijdelijke voorbehoedsmiddelen is een kleinere zonde dan het ondergaan van een sterilisatie; of abortus binnen 45 dagen is een kleinere zonde dan een abortus na 45 dagen.

Conclusie

De resultaten van het onderzoek laten zien dat generalisaties betreffende de pronataliteit van Moslims vaak overdreven zijn. Religie speelt zeker een belangrijke rol in de vruchtbaarheid van gelovigen. Echter, de invloed en kracht van religie is vaak contextueel bepaald, en is bijvoorbeeld afhankelijk van minderheid of meerderheid status, of sociaal economische status. Samenvattend laat het onderzoek zien dat, los van religie, mensen in staat zijn om hun reproductie vorm te geven en dat ze dat doen met een oog op het belang van hun gezin. D.w.z. zoals blijkt uit de interviews: mensen kiezen voor de *kwaliteit* van kinderen (waarbij opleiding, levensstandaard belangrijk zijn) en *niet* voor de *kwantiteit* van kinderen.

ସାରାଂଶ

ଭାରତ ଓ ବାଂଲାଦେଶରେ ହିନ୍ଦୁ ଓ ମୁସଲମାନ–ମାନଙ୍କ ମଧ୍ୟରେ ଧର୍ମ, ସଂଖ୍ୟାଲଘୁ ସ୍ଥିତି ଏବଂ ପ୍ରଜଜନ ବ୍ୟବହାର(ଆଚରଣ)

ଉପକ୍ରମ

ପ୍ରଜଜନ ଆଚରଣ ସ୍ଥିର କରିବା କ୍ଷେତ୍ରରେ ଧର୍ମ ଅପରିମେୟ ଗୁରୁତ୍ୱପୂର୍ଣ୍ଣ ଭୂମିକା ଧାରଣ କରେ, ଏହାର କାରଣ ଲୋକମାନେ, ଯେଉଁମାନେ ସମଧର୍ମ ଅନ୍ତର୍ଭୁକ୍ତ ସେମାନଙ୍କଠାରେ ଏକ ନିର୍ଦ୍ଦିଷ୍ଟ ନିୟମିତତା ପରିସର ଆଶା କରାଯାଏ । ଏହି ନିୟମିତତା ଗୋଟିଏ ଧାର୍ମିକ ଗୋଷ୍ଠୀ ପ୍ରଜଜନ ପରିସର ଆଶା କରାଯାଏ କାରଣ ସମଧର୍ମାବଲମ୍ବି ବ୍ୟକ୍ତିମାନେ ନିଜ ଧାର୍ମିକ ନିୟମ କାନୁନ ଦ୍ୱାରା ପରିଚାଳିତ ହେବାର ବିଶ୍ୱାସ କରାଯାଏ । ଧାର୍ମିକ ନିୟମମାନ ପ୍ରଜଜନ ଓ ପରିବାର ନିୟନ୍ତ୍ରଣ ଦିଗରେ ଧାର୍ମିକ ବିଶ୍ୱାସୀମାନଙ୍କୁ ପ୍ରଭାବିତ କରିବା ଓ ସେମାନଙ୍କର ମନୋବୃତ୍ତିକୁ ନିୟନ୍ତ୍ରଣ କରିବା କ୍ଷେତ୍ରରେ ପ୍ରଭାବିତ କରେ ବୋଲି କୁହାଯାଏ ।

ଧାର୍ମିକ ଗୋଷ୍ଠୀମାନଙ୍କର ପ୍ରଜଜନ ଆଚରଣ ପାଇଁ ଅନେକ ବ୍ୟାଖ୍ୟା କରାଯାଇଅଛି ଏବଂ ଏହାକୁ ବିସ୍ତୃତ ଭାବରେ ୪ଭାଗରେ ବିଭକ୍ତ କରାଯାଇ ପାରିବ ।

- ସ୍ୱଭାବସିଦ୍ଧ ଉପକଳ୍ପନା ଯୁକ୍ତି ଦର୍ଶାଏ ଯେ ପ୍ରଜଜନ ଓ ଗର୍ଭନିରୋଧକ ବ୍ୟବହାରର ଧାର୍ମିକ ବୈସାଦୃଶ୍ୟ ଜନ୍ମ ଓ ମୃତ୍ୟୁର ହିସାବ ଏବଂ ସାମାଜିକ ଓ ଅର୍ଥନୈତିକ ପ୍ରଭେଦରୁ ହିଁ ସୃଷ୍ଟି ହୁଏ ।
- ଏକ ନିର୍ଦ୍ଦିଷ୍ଟ ଧର୍ମତତ୍ତ୍ୱ ଉପକଳ୍ପନା ଯୁକ୍ତି ଦର୍ଶାଏ ଯେ ଧାର୍ମିକ ତତ୍ତ୍ୱ ଓ ଆଦର୍ଶ ଗର୍ଭନିରୋଧକ ସାମଗ୍ରୀ ଓ ପ୍ରଜଜନକୁ ପ୍ରଭାବିତ କରେ ।
- ସଂଖ୍ୟାଲଘୁ ସ୍ଥିତି ଉପକଳ୍ପନା ଦର୍ଶାଏ ଯେ ସଂଖ୍ୟାଲଘୁ ଗୋଷ୍ଠୀ ସହିତ ଜଡ଼ିତ ପ୍ରାନ୍ତ, ବିପଦ ସଂକୁଳତା ଓ ଉର୍ଦ୍ଧ୍ୱଗାମୀ ଗତିଶୀଳତାର ଅଭାବ ଗର୍ଭନିରୋଧକ ବ୍ୟବହାର ଓ ପ୍ରଜଜନ ଆଚରଣକୁ ପ୍ରଭାବିତ କରେ ।
- ପାରସ୍ପାରିକ ଉପକଳ୍ପନା ଯୁକ୍ତିଦ୍ୱାରା ସମର୍ଥନ କରେ ଯେ ପ୍ରଜଜନ ବ୍ୟବଧାନତା ଧାର୍ମିକ ଗୋଷ୍ଠୀମାନଙ୍କ ସ୍ଥିତି ଓ ସେହି ଗୋଷ୍ଠୀମାନଙ୍କର ଆଞ୍ଚଳିକ ସଚେତନତା ସନ୍ତାନ ଉତ୍ପାଦନ ଓ ପ୍ରଜଜନର ପାରସ୍ପାରିକ କାର୍ଯ୍ୟକ୍ଷମତା ଉପରେ ନିର୍ଭର କରେ ।

ବିଲ୍ୟନ ଭାବେ ମୁସଲମାନମାନଙ୍କ ପ୍ରଜଜନ ଶିକ୍ଷାଗତ ଓ ରାଜନୈତିକ ଦୃଷ୍ଟିକୋଣକୁ ସଞ୍ଚୟ କରି ରଖିଅଛି । ମୁସଲମାନମାନଙ୍କ ପ୍ରଜଜନ ଦୃଷ୍ଟିକୋଣ ଇସଲାମିକ୍ ନିୟମକାନୁନ୍‌ରୁ ଉତ୍ପନ୍ନ ଯେକି ପ୍ରଜଜନର ବିପରିତାର୍ଥ ବୋଲି ବିଶ୍ୱାସ କରାଯାଏ । ମୁଖ୍ୟତଃ ବନ୍ଧ୍ୟାତ୍ୱର ବ୍ୟବହାର ଓ ଗର୍ଭପାତ ପ୍ରଣୋଦିତ କରିବାକୁ କଟକଣା । ପ୍ରାକ୍ ଜନ୍ମିତ ମୁସଲମାନମାନଙ୍କର ଏହି ଚିନ୍ତାଧାରା ବିଦ୍ୱାନମାନଙ୍କ ଦ୍ୱାରା ପ୍ରତିଦ୍ୱନ୍ଦ୍ୱିତା କରୁଛି ଯେଉଁମାନେ ଚିନ୍ତା ବ୍ୟକ୍ତ କରନ୍ତି ଯେ ଦେଶସାରା ଏକ ସମାନ ପ୍ରକାର ପ୍ରଜଜନ ନିୟମ ପ୍ରୟୋଗ କରିବା ସମ୍ଭବ ନୁହେଁ । ଦକ୍ଷିଣ ଏସିଆ ବ୍ୟକ୍ତିମାନଙ୍କ ଚିନ୍ତାଧାରାରେ ଭାରତୀୟ ମୁସଲମାନମାନେ ଅପରାଂଶ ହିନ୍ଦୁମାନଙ୍କ ତୁଳନାରେ ଅଧିକ ପ୍ରଜଜନ କ୍ଷମତା ଅଛି । ଭାରତରେ ମୁସଲମାନମାନଙ୍କ ପ୍ରଜଜନକୁ ରାଜନୈତିକ ରୂପ ଦିଆଯାଇଅଛି ଯେଉଁଠାରେ ମୁସଲମାନମାନେ ହିନ୍ଦୁ ଧାର୍ମିକ ଗରିଷ୍ଠତାକୁ ପଛରେ ପକାଇ ଦେବେ ।

ମୁସଲମାନମାନେ ଭାରତରେ ସବୁଠାରୁ ବହୁତ ଧାର୍ମିକ ସଂଖ୍ୟାଲଘୁ (୧୩.୪ ପ୍ରତିଶତ) ଏବଂ ବାଲାଂଦେଶରେ ସଂଖ୍ୟା ଗରିଷ୍ଠ (୮୭.୮ ପ୍ରତିଶତ) । ତୁଳନାତ୍ମକ ଭାବେ, ଭାରତରେ ହିନ୍ଦୁମାନେ ସଂଖ୍ୟା ଗରିଷ୍ଠ (୮୦.୫ ପ୍ରତିଶତ) ଅଟନ୍ତି ଏବଂ ବାଂଲାଦେଶରେ ସବୁଠାରୁ ଅଧିକ ସଂଖ୍ୟାଲଘୁ (୯.୩ ପ୍ରତିଶତ) । ଭାରତ ଓ ବାଲାଂଦେଶରେ ଥିବା ଏହି ଅଦ୍ୱିତୀୟ ହିନ୍ଦୁ–ମୁସଲମାନ ସଂଯୋଗ ଏକ କ୍ଷମତାଶାଳୀ ଅନୁସଂଧାନ ପରୀକ୍ଷା କରିବାକୁ ଧର୍ମ ଓ ସଂଖ୍ୟାଲଘୁ ସ୍ଥିତି ବିଷୟରେ ଯୋଗାଇ ଦିଏ ଏବଂ ଭାରତ ଓ ବାଂଲାଦେଶରେ ଥିବା ଏହି ଦୁଇ ଧାର୍ମିକ ଗୋଷ୍ଠୀମାନଙ୍କ ପ୍ରଜଜନ ପ୍ରଭେଦ ବିଷୟରେ ବ୍ୟାଖ୍ୟା କରେ ।

ଗବେଷଣାର ଲକ୍ଷ୍ୟ ଏବଂ ନିର୍ଦ୍ଦିଷ୍ଟ ଗବେଷଣାତ୍ମକ ପ୍ରଶ୍ନ

ବର୍ତ୍ତମାନର ଗବେଷଣା ନିମ୍ନଲିଖିତ ଗବେଷଣାର ଲକ୍ଷ୍ୟ ଏବଂ ନିର୍ଦ୍ଦିଷ୍ଟ ଗବେଷଣାତ୍ମକ ପ୍ରଶ୍ନାବଳୀର ଉତ୍ତର ଦେବାକୁ ଅନୁସନ୍ଧାନ ଚଳାଉଛି ।

ଗବେଷଣାତ୍ମକ ଲକ୍ଷ୍ୟ

୧– ବର୍ତ୍ତମାନର ଗବେଷଣା ସହିତ ଜଡ଼ିତ ପ୍ରଶ୍ନାବଳୀ ଏକ ତୁଳନାତ୍ମକ ପଥ ଗ୍ରହଣ କରେ ଯେକି ଭାରତ ଓ ବାଂଲାଦେଶରେ ଥିବା ଧର୍ମ,ସଂଖ୍ୟାଲଘୁ ସ୍ଥିତି ଓ ପ୍ରଜଜନ ଆଚରଣର ମାଧ୍ୟମ ମାନଙ୍କର ଭୂମିକା ସମ୍ପର୍କରେ ଜାଣିବାକୁ ଅନୁସନ୍ଧାନ ଜାରି ରଖିଛି ।

୧.୧– ଦୁଇଦେଶ ଭାରତ ଓ ବାଂଲାଦେଶ ସ୍ତରରେ ଏବଂ ଭାରତ ମଧ୍ୟରେ ଧାର୍ମିକ ସଂଖ୍ୟାଲଘୁ ସ୍ଥିତିର ପ୍ରଭାବ କ'ଣ ଅଟେ ?

୧.୨– ଭାରତ ଓ ବାଂଲାଦେଶରେ ହିନ୍ଦୁ ଓ ମୁସଲମାନମାନଙ୍କର ପ୍ରଜଜନ ବ୍ୟାଖ୍ୟା କରିବାରେ ଧର୍ମର ପ୍ରଭାବ କ'ଣ ଅଟେ ?

୧.୩– ଭାରତ ମୁସଲମାନଙ୍କ ସହିତ ବାଂଲାଦେଶରେ ପ୍ରଜଜନ ଆଚରଣ ଠାରୁ କ'ଣ ଶିକ୍ଷା କରାଯାଇପାରିବ ?

ଗବେଷଣାତ୍ମକ ଲକ୍ଷ୍ୟ

୨– ଭାରତ ଓ ବାଂଲାଦେଶ ଦ୍ୱିପାକ୍ଷିକ କାର୍ଯ୍ୟକ୍ରମ ଧାର୍ମିକ ପରିସରରେ ପ୍ରଜଜନ ଆଚରଣ କ୍ଷେତ୍ରରେ ଏଜେନ୍‌ସି ଭୂମିକା କ'ଣ ଅଟେ ।

୨.୧– ଭାରତ ଓ ବାଂଲାଦେଶରେ ସ୍ତ୍ରୀଲୋକମାନଙ୍କର ପ୍ରଜଜନ ଅଭିଳାଷକୁ ଅନୁଭବ କରିବାକୁ ଇସଲାମ ଧର୍ମ ସହିତ ସମ୍ପର୍କ କିପରି ?

ସିଦ୍ଧାନ୍ତିକ ଆଧାର

ଦକ୍ଷିଣ ଏସିଆରେ ପ୍ରଜଜନ ଓ ଧର୍ମ ସହିତ ଜଡ଼ିତ ଡେମୋଗ୍ରାଫିକ୍ ଅଧ୍ୟୟନ ଧର୍ମକୁ ଏକ ସାଂସ୍କୃତିକ ''କଳାବାକ୍ସ'' ବୋଲି ବିବେଚନା କରିଅଛି । ଅନ୍ତର୍ନିହିତ ପଦ୍ଧତିର ଯଥେଷ୍ଟ ପରିମାଣ ଆବିଷ୍କାର କରିବା ବିନା ଯାହା ମାଧ୍ୟମରେ ଧର୍ମ ପ୍ରଜଜନ ଆଚରଣକୁ ପ୍ରଭାବିତ କରେ । ବର୍ତ୍ତମାନର ପରୀକ୍ଷା ଅନ୍ତର୍ନିହିତ ପଦ୍ଧତିକୁ ବୁଝିବାକୁ ଅନ୍ୱେଷଣ କରେ ଯାହା ମାଧ୍ୟମରେ ଧର୍ମ ଓ ପ୍ରଜଜନ ଆଚରଣ ପରସ୍ପର ମଧ୍ୟରେ ଜଡ଼ିତ ।

ବର୍ତ୍ତମାନର ଅଧ୍ୟୟନ ଧାର୍ମିକ ଗୋଷ୍ଠୀମାନଙ୍କର ପ୍ରଜଜନ ଆଚରଣକୁ ବ୍ୟାଖ୍ୟା କରି ମାକ୍ରୋ–ମାଇକ୍ରୋ ସମ୍ପର୍କ ବିବେଚନା କରିବାକୁ ଗଠନ ପ୍ରଣାଳୀ ମତବାଦ ଗ୍ରହଣ କରିଛି । ମାକ୍ରୋସ୍ତର (ପଦ୍ଧତି) କିମ୍ବା ଗଠନ ପ୍ରଣାଳୀ, ସମାଜ, ସାମାଜିକ ପଦ୍ଧତି ଓ ଅନୁଷ୍ଠାନମାନଙ୍କ ବିଷୟରେ ପ୍ରକାଶ କରୁଅଛି । ମାଇକ୍ରୋ ସ୍ତର (ପଦ୍ଧତି) କିମ୍ବା ଏଜେନ୍‌ସି ବ୍ୟକ୍ତି କାର୍ଯ୍ୟ, ପାରିଷ୍ପାରିକ କ୍ରିୟା, ପରିସ୍ଥିତିର ବ୍ୟାଖ୍ୟା ଏବଂ ଏହା ସହିତ ଜଡ଼ିତ ଅର୍ଥ ପ୍ରକାଶ କରୁଅଛି । ଗଠନ ପ୍ରଣାଳୀ ଯୁକ୍ତି ଦର୍ଶାଏ ଯେ ଏଜେନ୍‌ସି ଓ ଗଠନ, ଦ୍ୱୈତ ମାଧ୍ୟମ ମଧ୍ୟରେ ପାରସ୍ପାରିକ ନିର୍ଭରଶୀଳ ଦ୍ୱିତବାଚକ ।

ବୋଙ୍ଗାଟିସ୍ ଓ ପୋଟର (୧୯୮୩) ଯିଏ ବିକାଶଶୀଳ ପୃଥିବୀରେ ପ୍ରଜଜନ ଅନୁସନ୍ଧାନ ପାଇଁ ଏକ ସମ୍ୟକ୍ ମାନଦଣ୍ଡ ଯୋଗାଇଦିଏ ପ୍ରଜଜନ ନିକଟ ସମ୍ପର୍କୀୟ ନିର୍ଣ୍ଣାୟକ ଗ୍ରହଣ କରେ ।

ଦତ୍ତବିଷୟ ଓ ପଦ୍ଧତି

ପ୍ରଥମ ଗବେଷଣା ପ୍ରଶ୍ନର (୧.୧) ଉତ୍ତର ଦେବାକୁ, ପଠିତ ବିଷୟ ମାଧ୍ୟମିକ ଦତ୍ତବିଷୟ ବ୍ୟବହାର କରେ । ଦ୍ୱିତୀୟ (୧.୨), ତୃତୀୟ (୧.୩) ଓ ଚତୁର୍ଥ (୨.୧) ଗବେଷଣା ପ୍ରଶ୍ନର ଉତ୍ତର ଦେବାକୁ, ପ୍ରାଥମିକ ଦତ୍ତବିଷୟ ନିୟୋଜିତ କରାଯାଇଅଛି । ମାଧ୍ୟମିକ ଦତ୍ତବିଷୟ ଭାରତ ଓ ବାଂଲାଦେଶର ଡେମୋଗ୍ରାଫିକ ସ୍ୱାସ୍ଥ୍ୟ ପରିସଂଖ୍ୟାନ ଓ ଜନଗଣନାରେ ନିହିତ । ପ୍ରାଥମିକ ଦତ୍ତବିଷୟ ସଂଗ୍ରହ କରିବାପାଇଁ ବର୍ତ୍ତମାନର ଅନୁସନ୍ଧାନ ଏକ ମିଶ୍ର–ପଦ୍ଧତି ଗବେଷଣା ପରିକଳ୍ପନା ବ୍ୟବହାର କରିଅଛି । ଏକ ମିଶ୍ର–ପଦ୍ଧତି ଗବେଷଣା ପରିକଳ୍ପନା ଗୁଣାତ୍ମକ ଓ ପରିମାଣ ପଦ୍ଧତିର ବ୍ୟବହାରକୁ ଅଧିକାର କରେ । ଏହି ପଦ୍ଧତିଗୁଡ଼ିକ ପର୍ଯ୍ୟାୟକ୍ରମ ପ୍ରଣାଳୀରେ ବ୍ୟବହାର କରାଯାଇଅଛି । ଯେଉଁଠି ପ୍ରତ୍ୟେକ ପଦ୍ଧତିର ବ୍ୟବହାର ଅନ୍ୟ ପଦ୍ଧତି ଅନୁପୂରକ । ଅଧିକନ୍ତୁ, ପ୍ରତ୍ୟେକ ପଦ୍ଧତିର ବ୍ୟବହାର ଅନ୍ୟ ପଦ୍ଧତିର ଉନ୍ନତି ନିମନ୍ତେ ସାହାଯ୍ୟ କରେ । ଗୁଣାତ୍ମକ ପଦ୍ଧତି ବ୍ୟବହାର କରି ସଂଗୃହୀତ ଦତ୍ତ ବିଷୟ ସାକ୍ଷାତକାର ଏବଂ ମୂଳ ସଂବାଦଦାତା ଉପରେ ପର୍ଯ୍ୟବେକ୍ଷିତ (N=112) । ପରିମାଣ ପଦ୍ଧତି ବ୍ୟବହାର କରି ସଂଗୃହୀତ ଦତ୍ତବିଷୟ ପର୍ଯ୍ୟବେକ୍ଷଣ ପଦ୍ଧତି ମାଧ୍ୟମରେ ଅଛି ।

ମୁଖ୍ୟ ପ୍ରାପ୍ତବସ୍ତୁ

୧. ଭାରତର (ଜନଗଣନା ଦତ୍ତବିଷୟ) ଜିଲ୍ଲାସ୍ତରୀୟ ଅନୁଶୀଳନୀରୁ ମିଳିଥିବା ପର୍ଯ୍ୟବେକ୍ଷଣ ଫଳାଫଳ ପ୍ରକାଶ କରେ କି ଏକାଗ୍ରତା ଅନୁକ୍ରମଣିକା ସୂଚନାର ପ୍ରଭାବ ଉଭୟେ ହିନ୍ଦୁ ଓ ମୁସଲମାନମାନଙ୍କର ପ୍ରଜଜନ ସ୍ତର ପାଇଁ ନାସ୍ତିସୂଚକ । ଏହି ଏକାଗ୍ରତା ଅନୁକ୍ରମଣିକା ସୂଚନାର ନାସ୍ତିବାଚକ ନମୁନା ସଂଖ୍ୟାଲଘୁ ପରିକଳ୍ପନାକୁ ସମର୍ଥନ କରେ । ଯେଉଁ ଜିଲ୍ଲାର ଜନସଂଖ୍ୟାରେ ଧାର୍ମିକ ଗୋଷ୍ଠୀମାନଙ୍କର ଭାଗ ଯେତେ କମ୍, ଟିଏଫ୍‌ଆର ସେତେ ଅଧିକ । ଫଳାଫଳ ଅଧିକରୁ ଯୁକ୍ତି ଦର୍ଶାଏ ଯେ ସଂଖ୍ୟାଲଘୁ ସ୍ଥିତି ଓ ପ୍ରଜଜନ ମଧ୍ୟରେ ଥିବା ନାସ୍ତିସୂଚକ ସମ୍ପର୍କ ଗୋଟିଏ ଧର୍ମରେ ସୀମାବଦ୍ଧ ହୋଇ ରହିନାହିଁ, ତାହା ମୁସଲମାନମାନେ (୦.୦୫) କିନ୍ତୁ ଏହା ମଧ୍ୟ ହିନ୍ଦୁମାନଙ୍କ (୦.୦୧) ପାଇଁ ଯଥାର୍ଥ ଓ ତୁଳନାତ୍ମକ ଭାବେ ଶକ୍ତ ।

୨. ଜିଲ୍ଲା ସ୍ତରରେ ମୁସଲମାନ ଧର୍ମର ସଂଖ୍ୟାଲଘୁମାନଙ୍କର ଅଧିକ ପ୍ରଜଜନ, ଆମେ ବ୍ୟାଖ୍ୟାକରୁ, ସାମାଜିକ ଅର୍ଥନୈତିକ ପ୍ରତିକୂଳ ଅବସ୍ଥାର ଫଳାଫଳ ଯାହା କି ଭାରତରେ ଥିବା ସଂଖ୍ୟା ଲଘୁ ମୁସଲମାନମାନଙ୍କର ଅନୁଭୂତି ଏକାଗ୍ରତା ଆବାସିକ (CRPS) ଯେଉଁଠି ମୁସଲମାନମାନେ ଯଥେଷ୍ଟ ସାମାଜିକ ଅର୍ଥନୈତିକ ଭିତ୍ତିଭୂମି ନିୟମ ଅଭାବରେ ବସବାସ କରନ୍ତି ।

ସ୍ୱାସ୍ଥ୍ୟ–ସେବା, ଶିକ୍ଷାନୁଷ୍ଠାନ ଏବଂ ମୁସଲମାନମାନଙ୍କର ଯୋଗାଯୋଗ ଭଳି ସାମାଜିକ –ଅର୍ଥନୈତିକ ଭିତ୍ତିଭୂମିର ଅଭାବ ମୁସଲମାନମାନଙ୍କର ଉକ୍ତ ସେବାର ସୀମିତ କରୁଛି । ଏହା ଏକ ଜଣାଶୁଣା ଘଟଣା ଯେ ସାମାଜିକ–ଅର୍ଥନୈତିକ ସ୍ଥିତି ପ୍ରଜଜନ ଆଚରଣରେ ଗଭୀର ପ୍ରଭାବ ପକାଏ । ତେଣୁ ମୁସଲମାନ ସ୍ଥିତିର ଏହିଭଳି ସାମାଜିକ ଅର୍ଥନୈତିକ ଅସୁବିଧାଗୁଡ଼ିକୁ ମୁସଲମାନମାନଙ୍କ ପାଇଁ ପ୍ରଜଜନ ପସନ୍ଦ ଧାରଣା ଦେବାକୁ ସଂଘଟିତ କରେ ନାହିଁ ।

୩. ଯେଉଁ ଜିଲ୍ଲାରେ ହିନ୍ଦୁମାନେ ସଂଖ୍ୟାଲଘୁ ଅଟନ୍ତି କିମ୍ବା ଅନ୍ୟ ଅର୍ଥରେ ଯେଉଁ ଜିଲ୍ଲାରେ ମୁସଲମାନମାନେ ସଂଖ୍ୟା ଗରିଷ୍ଠତା ଗଠନ କରନ୍ତି । ସ୍ଥିତାବସ୍ଥାରେ ଅବହେଳିତ ହେଉଅଛନ୍ତି (GOI 2006) । ତେଣୁ ଆମେ ବ୍ୟାଖ୍ୟା କରୁକି ସେହି ଅଞ୍ଚଳରେ ମୁସଲମାନମାନଙ୍କ

ପରି ହିନ୍ଦୁମାନେ, ଯେଉଁମାନେ ମୁସଲମାନ ସଂଖ୍ୟା ଗରିଷ୍ଠତା ଅଞ୍ଚଳରେ ବସବାସ କରନ୍ତି । ସେହି ଏକା ସାମାଜିକ ଅର୍ଥନୈତିକ ସ୍ଥିତିର ଅଭାବ ପରି ଯନ୍ତ୍ରଣା ଭୋଗ କରନ୍ତି । ଏହା ସମ୍ଭବତଃ କାରଣ ବର୍ଣ୍ଣନା କରେ ଜିଲ୍ଲାସ୍ତରରେ ହିନ୍ଦୁମାନଙ୍କର ପ୍ରଜଜନ କ୍ଷେତ୍ରରେ ସଂଖ୍ୟାଲଘୁ ହିନ୍ଦୁମାନଙ୍କ ସ୍ଥିତି ଉପରେ ଦୃଢ଼ ପ୍ରଭାବ ଏହାର କାରଣ ।

୪. ଗୋଟିଏ ହିନ୍ଦୁ ମା' ଅପେକ୍ଷା ଗୋଟିଏ ମୁସଲମାନ ମା' ଶୀଘ୍ର ଦ୍ୱିତୀୟ ଓ ତୃତୀୟ ସନ୍ତାନ ଜନ୍ମ କରିବାରେ ସ୍ୱଳ୍ପତଃ ଅଧିକ ବିପଦର ସମ୍ମୁଖୀନ ହୁଏ । ଯାହାହେଉ ବ୍ୟକ୍ତିଗତ ଧର୍ମ ଭାରତରେ ଉଭ ହିନ୍ଦୁ ଓ ମୁସଲମାନମାନଙ୍କର ଦଳ ମଧ୍ୟରେ ପରିବର୍ତ୍ତନର ପ୍ରଭାବ ପାଇଥାଉ । ତେଣୁ ପ୍ରଜଜନ ପରିଣାମ ସହିତ ଧର୍ମର ଦୁଇ ପଦକ୍ଷେପ (ଧାର୍ମିକ ଗୋଷ୍ଠୀ ଅନ୍ତର୍ଭୁକ୍ତ ଓ ଧର୍ମ) କୌଣସି ସିଦ୍ଧାନ୍ତିକ ଫଳାଫଳ ଉତ୍ପାଦନ କରିନାହିଁ । ଅଧିକନ୍ତୁ ଏକ ଧର୍ମବାଲମ୍ବୀ ହେଲେବି ଭାରତୀୟ ମୁସଲମାନମାନେ ବାଂଲାଦେଶର ମୁସଲମାନମାନଙ୍କ ତୁଳନାରେ ଏକରୁ ଅଧିକ ପ୍ରଜଜନ ମାଧ୍ୟମ ଅନୁକରଣ କରନ୍ତି । ଏହି ଅନୁଧ୍ୟାନ ଯୁକ୍ତି ଦର୍ଶାଏ ଯେ ଇସଲାମ ଧର୍ମର ନିୟମଗୁଡ଼ିକ ମୁଖ୍ୟ ପଥ ନୁହେଁ, ଯାହା ମାଧ୍ୟମରେ ମୁସଲମାନମାନଙ୍କର ପ୍ରଜଜନ ଉପଚାର ବର୍ଣ୍ଣନା କରାଯାଇପାରିବ । ତେଣୁ ନିର୍ଦ୍ଦିଷ୍ଟ ଧର୍ମତତ୍ତ୍ୱ ଉପକଳ୍ପନା ତାହା ପ୍ରଜଜନରେ ଧର୍ମର ସ୍ୱାଧୀନ ପ୍ରଭାବକୁ ପ୍ରତ୍ୟାଖ୍ୟାନ କରାଯାଇଅଛି ।

୫. ବ୍ୟବଧାନିକ ମୁସଲମାନ ପ୍ରଜଜନ ପାଇଁ ଏକ ସମ୍ଭାବ୍ୟ ବ୍ୟାଖ୍ୟା । ଭାରତ ଓ ବାଂଲାଦେଶରେ ମୁସଲମାନମାନଙ୍କ ଦ୍ୱାରା ବ୍ୟବହୃତ ହେଉଥିବା ଗର୍ଭନିରୋଧକ ପଦ୍ଧତି ଗୁଡ଼ିକର ତାରତମ୍ୟ ଆରୋପ କରାଯାଇପାରିବ । ଉଭୟ ଦେଶରେ ମୁସଲମାନମାନେ ଶେଷପଥ ଅପେକ୍ଷା ଅସ୍ଥାୟୀ ପଦ୍ଧତିକୁ ଅନୁଗ୍ରହ କରିବା ଜଣାପଡ଼ନ୍ତି । ଭାରତର ମୁସଲମାନମାନେ ଅସ୍ଥାୟୀ ପଦ୍ଧତି ସହିତ ଗର୍ଭନିରୋଧକ ପଦ୍ଧତି ବ୍ୟବହାର କରିବାକୁ ବାଧ ହୁଅନ୍ତି । ଅନ୍ୟ ପକ୍ଷରେ ବାଂଲାଦେଶର ମୁସଲମାନମାନେ କେବଳ ଅସ୍ଥାୟୀ ଗର୍ଭନିରୋଧକ ପଦ୍ଧତିର ବ୍ୟବହାର କରନ୍ତି । ଅଧିକନ୍ତୁ, ଭାରତରେ ହିନ୍ଦୁମାନଙ୍କ ଅପେକ୍ଷା ମୁସଲମାନମାନେ ଗର୍ଭନିରୋଧକ ପଦ୍ଧତି ବ୍ୟବହାର କରିବାକୁ କମ୍ ଅନୁରାଗୀ । ଏହା କେବଳ ଇସଲାମର ଗର୍ଭନିରୋଧକ ପଦ୍ଧତିର ବ୍ୟବହାର ଉପରେ ଥିବା କଟକଣା ଯୋଗୁ ଘଟେ । ବର୍ତ୍ତମାନର ଅନୁଧ୍ୟାନ ଯୁକ୍ତି ବାଢ଼େ ଯେ ଭାରତର ମୁସଲମାନଙ୍କ ଦ୍ୱାରା ବ୍ୟବହୃତ ହେଉଥିବା ଗର୍ଭନିରୋଧକ ଏହାର ବ୍ୟବହାର ନିମନ୍ତେ କମ୍ ଅନୁରାଗୀ ହେବା ସତ୍ତ୍ୱେ ଭାରତରେ ମୁସଲିମ୍‌ମାନଙ୍କ ଦ୍ୱାରା ବ୍ୟବହୃତ ହେଉଥିବା ଗର୍ଭନିରୋଧକ ଭାରତର ମୁସଲମାନମାନଙ୍କର ଅଧିକ ପ୍ରଜଜନ କ୍ଷମତା ଥାଏ ।

୬. ଉଚ୍ଚମାତ୍ରାର ସଂଯତ ଯୋଗୁ ଭାରତରେ ମୁସଲମାନମାନଙ୍କ ଉଚ୍ଚ ପ୍ରଜଜନ କ୍ଷମତା ବାଲଶଂଦେଶ ମୁସଲମାନମାନଙ୍କ ତୁଳନାରେ ଭାରତର ମୁସଲମାନମାନଙ୍କ ଦ୍ୱାରା ଅନୁଭୂତି କରାଯାଇଛି । ଗୋଟିଏ ପକ୍ଷରେ, ଭାରତୀୟ ପରିବାର ନିୟନ୍ତ୍ରଣ ଯୋଜନା ବନ୍ଧ୍ୟାତ୍ୱ ଉପରେ ମୁଖ୍ୟତଃ ପ୍ରଭାବ ପକାଇଛି ଏବଂ ଅନ୍ୟ ପକ୍ଷରେ, ବନ୍ଧ୍ୟାତ୍ୱ ଇସଲାମିକ ଧର୍ମାନୁସାରେ ସୀମିତ କରାଯାଇଛି । ତେଣୁ ଭାରତରେ ମୁସଲମାନ ଦମ୍ପତିମାନେ ବନ୍ଧ୍ୟାତ୍ୱ ପଦ୍ଧତି କାରଣରୁ ସଂଯତ ହୋଇଛନ୍ତି । ଇସଲାମ ଧର୍ମରେ ନିଷେଧ କରାଯାଇଥିବା ଗର୍ଭନିରୋଧକ ଜିନିଷ ଭାରତୀୟ ପରିବାର ନିୟନ୍ତ୍ରଣ ଯୋଜନା ଦ୍ୱାରା ଯୋଗାଇ ଦିଆଯାଉଛି । ଯାହାହେଉ ବାଲାଂଦେଶରେ ମୁସଲମାନ ଦମ୍ପତି ଗର୍ଭନିରୋଧର ଅସ୍ଥାୟୀ ପଦ୍ଧତି ଯୋଗୁ ସଂଯତ ହେଉନାହାନ୍ତି । ଇସଲାମ ଧର୍ମରେ ଅନୁମୋଦନ ଆକାରରେ ଅଟେ ଯାହା ଦମ୍ପତିମାନଙ୍କ ଉପରେ ଜବରଦସ୍ତ ଲଦି ଦିଆଯାଉଅଛି । ଯେଉଁମାନେ ଇସଲାମ ଧର୍ମରେ ନିଷେଧ ହୋଇଥିବା ଗର୍ଭନିରୋଧକ ଓ ବନ୍ଧ୍ୟାତ୍ୱ ବ୍ୟବହାର କରନ୍ତି । ଯାହେଉ ବାଂଲାଦେଶର ମୁସଲମାନ ଦମ୍ପତ୍ତିମାନେ ଏକ ପ୍ରକାରର ଅନୁମୋଦନର ସମ୍ମୁଖୀନ ହୁଅନ୍ତି ନାହିଁ କାରଣ ସେମାନେ ବନ୍ଧ୍ୟାତ୍ୱ ପଦ୍ଧତି ବ୍ୟବହାର କରିବାକୁ କମ୍ ଉତ୍ସାହୀ ଅଟନ୍ତି । ଭାରତରେ ମୁସଲମାନ ଯୁବ ଦମ୍ପତିମାନଙ୍କ ପାଇଁ ଅସମାନ ଶକ୍ତି ସମ୍ପର୍କ ଓ ଲିଙ୍ଗ ନିୟମ ଯୋଗୁ ଅତିରିକ୍ତ ପ୍ରତିବନ୍ଧକ ସୃଷ୍ଟି କରାଯାଇଛି । ଭାରତରେ ମୁସଲମାନମାନେ ନିରାପତ୍ତା ଦୃଷ୍ଟିରୁ ସିଆରପିଏସ୍‌ରେ ବସବାସ କରିବାକୁ ବାଧ ହେଉଛନ୍ତି ଯାହା ଭାରତରେ ହିନ୍ଦୁ ଓ ମୁସଲମାନମାନଙ୍କ ମଧ୍ୟରେ ସାଂପ୍ରଦାୟିକ ଦଙ୍ଗାର ଫଳାଫଳ ଏବଂ ସେମାନଙ୍କର ନିଛାଟିଆକୁ ସଂଯୋଗ କରେ । ଭାରତର କର୍ଣ୍ଣାଟକରେ ସ୍ୱଷ୍ଟ ଭାଷାଗତ ଗୁଣ ଅଛି କାରଣ ମୁସଲମାନମାନେ ''ଧାକନୀ'' ଭାଷା କୁହନ୍ତି ଯେଉଁ ଭାଷା ସଂଖ୍ୟା ଗରିଷ୍ଠ ସଂପ୍ରଦାୟ କହୁଥିବା ଭାଷାଠାରୁ ସମ୍ପୂର୍ଣ୍ଣ ଭିନ୍ନ ଯାହାକୁ 'କନାଡ଼' ଭାଷା ବୋଲି କୁହାଯାଏ । ମୁସଲମାନମାନଙ୍କର ସ୍ୱଷ୍ଟ ଭାଷାଗତ ପରିଚୟ ସାମ୍ପ୍ରଦାୟିକ ପ୍ରଜଜନ ସେବାର ଉପାଦେୟତା ଠାରୁ ସାମ୍ପ୍ରଦାୟିକ ବିଚ୍ଛିନ୍ନତାକୁ ସାହାଯ୍ୟ କରେ । ତେଣୁ ଏହି ବିଚ୍ଛିନ୍ନତା ପ୍ରଜଜନ ସ୍ୱାସ୍ଥ୍ୟ ଅବଗତି ପରିବ୍ୟାପ୍ତକୁ ପ୍ରତିରୋଧ କରେ । ଯାହାହେଉ ବାଂଲାଦେଶର ମୁସଲମାନମାନେ ପ୍ରଜଜନ ସ୍ୱାସ୍ଥ୍ୟ ଅବଗତି ପରିବ୍ୟାପ୍ତ ପାଇଁ କୌଣସି ପ୍ରତିବନ୍ଧକର ସମ୍ମୁଖୀନ ହୁଅନ୍ତି ନାହିଁ । କାରଣ ସେମାନେ ଆବାସିକ ଭାବେ ଅଲଗା ନୁହଁନ୍ତି କି ସେମାନଙ୍କର ଏକ ସ୍ୱଷ୍ଟ ଭାଷାଗତ ପରିଚୟ ମଧ୍ୟ ନାହିଁ ।

୭. ମୁସଲମାନ ସ୍ତ୍ରୀଲୋକମାନେ ଧାର୍ମିକ ନିୟମକାନୁନର ଉଦାସୀନ ଅନୁସରଣକାରୀ ନୁହଁନ୍ତି କିନ୍ତୁ ସକ୍ରୀୟ କଳାକାର ଯିଏ ପ୍ରଜଜନ କ୍ଷେତ୍ରରେ ସମସ୍ତ ନିୟମ ଆଦେଶକୁ ଉଲ୍ଲଙ୍ଘନ କରନ୍ତି ଏବଂ ପରିବାର ଗଠନ କ୍ଷେତ୍ରରେ ଏକ ସକ୍ରୀୟ ଭୂମିକା ଗ୍ରହଣ କରନ୍ତି । ଭାରତୀୟ ଓ ବାଂଲାଦେଶୀ କ୍ଷେତ୍ରରେ ଥିବା ପ୍ରଭେଦ ଏହି ଦୁଇ ଦେଶର ମୁସଲମାନ ସ୍ତ୍ରୀଲୋକମାନଙ୍କ ଦ୍ୱାରା ଉନ୍ନତି ହୋଇଥିବା ଅନ୍ୟାନ୍ୟ ନିର୍ଦ୍ଦିଟେ ପ୍ରାସଙ୍ଗିକ ଲକ୍ଷ୍ୟକୁ ବୃଦ୍ଧି କରାଇଅଛି ପ୍ରଜଜନ ଅଭିଳାଷକୁ ଅନୁଭବ କରିବାକୁ ।

୮. ଭାରତୀୟ ଦମ୍ପତି ଭାରତରେ ପରିବାର ନିୟନ୍ତ୍ରଣ ଯୋଜନା ଦ୍ୱାରା ଯୋଗାଇ ଦିଆଯାଉଥିବା ଗର୍ଭନିରୋଧକ ଭଳି ବନ୍ଧ୍ୟାତ୍ୱ ଯୋଗାଣରେ ବଡ଼ ପ୍ରତିବନ୍ଧକର ସମ୍ମୁଖୀନ ହୁଅନ୍ତି । ଅଧିକନ୍ତୁ ଭାରତୀୟ ମୁସଲମାନ ସ୍ତ୍ରୀଲୋକମାନେ ତାଙ୍କର ନିଜ ପରିବାରଠାରୁ

ଆପେକ୍ଷିକ ଭାବେ ଅଧିକ ପ୍ରତିବନ୍ଧକର ସମ୍ମୁଖୀନ ହୁଅନ୍ତି ଯେତେବେଳେ ସେମାନେ ବନ୍ଧ୍ୟାତ୍ୱ ଅବଲମ୍ବନ କରନ୍ତି ଏବଂ ଗର୍ଭପାତ କରାନ୍ତି । ଯାହାହେଉ ମୁସଲମାନ ସ୍ତ୍ରୀଲୋକମାନେ ନିଯୁକ୍ତିକ ପ୍ରୟୋଗ କରନ୍ତି । (ଗର୍ଭନିରୋଧକ କିମ୍ୱା ଗର୍ଭପାତ) କାର୍ଯ୍ୟ ଉପରେ ନୀରବତା ଅବଲମ୍ବନ କରି ସେମାନେ (ବନ୍ଧ୍ୟାତ୍ୱ କିମ୍ୱା ଗର୍ଭପାତ) ପରି ଧାର୍ମିକ ନିଷିଦ୍ଧ ପଦ୍ଧତି ବ୍ୟବହାର କରନ୍ତି । ପରିବାର ସଦସ୍ୟଙ୍କ ବିନା ଜ୍ଞାତରେ ଯେଉଁମାନେ ଏହି ପଦ୍ଧତି ଗୁଡ଼ିକୁ ବିରୋଧ କରନ୍ତି ।

୯. ଯାହାହେଉ ବାଂଲାଦେଶର ସ୍ତ୍ରୀଲୋକମାନେ ଇସଲାମ ଧର୍ମରେ ନିଷିଦ୍ଧ ପଦ୍ଧତି ବ୍ୟବହାର କରିବାପାଇଁ ଧର୍ମ ପ୍ରତିଷ୍ଠିତ ଯଥାର୍ଥତା ପ୍ରତିପାଦନ କରନ୍ତି । ବାଂଲାଦେଶ ସ୍ତ୍ରୀଲୋକମାନେ ଧର୍ମ ଉପରେ ପର୍ଯ୍ୟବେଶିତ ଯଥାର୍ଥତା ପ୍ରତିପାଦନ କରନ୍ତି । ବାଂଲାଦେଶ ସ୍ତ୍ରୀଲୋକମାନେ ଧର୍ମ ଉପରେ ପର୍ଯ୍ୟବେସିତ ଯଥାର୍ଥତା ବିଷୟରେ ଅଧିକ ଜ୍ଞାନ ଧାରଣ କରନ୍ତି । ଯାହା ମାଧ୍ୟମରେ ସେମାନେ ତୁଳନାତ୍ମକ ଭାବେ କମ୍ ପାପ କରନ୍ତି । ଯଦିଓ ସେମାନେ ନିୟମକାନୁନ ଉଲ୍ଲଘଂନ କରନ୍ତି । ଉଦାହରଣ ସ୍ୱରୂପ, ଅସ୍ଥାୟୀ ଗର୍ଭନିରୋଧକ ସ୍ଥାୟୀ ଗର୍ଭନିରୋଧକ ପଦ୍ଧତି ତୁଳନାରେ କମ୍ ପାପ, ଗର୍ଭଧାରଣ କରିବାର ୪୫ ଦିନ ମଧ୍ୟରେ ଗର୍ଭପାତ ପ୍ରୟୋଗ କରିବା ତୁଳନାତ୍ମକ ଭାବେ ତା ପରବର୍ତ୍ତୀ ସମୟରେ ଗର୍ଭପାତ କରାଇବାଠାରୁ କମ୍ ପାପ ।

ସିଦ୍ଧାନ୍ତ

ଅଭିଜ୍ଞତା–ସିଦ୍ଧ ଫଳାଫଳ ପ୍ରମାଣ କରେ ଯେ ମୁସଲମାନମାନଙ୍କ ପ୍ରଜଜନ ଓ ଜନ୍ମ ପରବର୍ତ୍ତୀ ଅବସ୍ଥା ସମ୍ବନ୍ଧୀୟ ସାର୍ବଜନୀନତା ବାରମ୍ବାର ଅତିରଞ୍ଜିତ ହୋଇଅଛି । ଧର୍ମ ଏହାର ଅନୁରାଗୀମାନଙ୍କର ପ୍ରଜଜନ କ୍ଷେତ୍ରରେ ଏକ ମୁଖ୍ୟ ଭୂମିକା ଗ୍ରହଣ କରେ, ଯାହାହେଉ, ଧର୍ମର ପ୍ରଭାବ ଓ ବିସ୍ତାର ବାରମ୍ବାର ପ୍ରାସଙ୍ଗିକ ଭାବେ ସ୍ଥିର କରାଯାଇଅଛି । (ଉଦାହରଣ ସ୍ୱରୂପ, ସଂଖ୍ୟା ଗରିଷ୍ଠ କିମ୍ୱା ସଂଖ୍ୟାଲଘୁ ସ୍ଥିତି, ସାମାଜିକ–ଅର୍ଥନୈତିକ ସ୍ଥିତି ଇତ୍ୟାଦି) । ସଂକ୍ଷେପରେ, ଧର୍ମର ପରିବର୍ତ୍ତେ, ଯଦି ଏକ ସୁସ୍ଥ ପରିବେଶ ଯୋଗାଇ ଦିଆଯାଏ, ଲୋକମାନେ ନିଜ ପରିବାରର ମଙ୍ଗଳ ନିମନ୍ତେ ପ୍ରଜଜନ ଉପଚାର ନିଜେ ଯୋଜନା କରିବେ । ତେଣୁ ଆମେ ଉକ୍ତ ସିଦ୍ଧାନ୍ତରେ ଉପନୀତ ଯେ ପ୍ରଜଜନ କ୍ଷେତ୍ରରେ ଲୋକମାନେ ପିଲାମାନଙ୍କର ପରିଣାମ୍ୱକ ଅପେକ୍ଷା ଗୁଣାମ୍ୱକ (ଶିକ୍ଷା, ବଞ୍ଚିବାର ସୁସ୍ଥତା) ଲାଳନପାଳନ କରିବାକୁ ଅଭ୍ୟାସ କରିବେ ।

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